A DESCRIPTIVE STUDY TO ASSESS THE BEHAVIOURL DISORDERS AMONG BOYS AND GIRLS BETWEEN THE AGE OF 5-10 YEARS AT GOVERNMENT MIDDLE SCHOOL, SAKKAYANAYAKKANUR, DINDIGUL.

Register number:301332851

A DISSERTATION SUBMITTED TO THE TAMILNADU DR.MGR.MEDICAL UNIVERSITY, CHENNAI, IN PARTIAL FULFILLMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

OCTOBER 2015

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INTERNAL EXAMINER **EXTERNAL EXAMINER**

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CERTIFICATE

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AGE OF 5-10 YEARS AT GOVERNMENT MIDDLE SCHOOL, SAKKAYANAYAKKANUR, DINDIGUL.

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ABSTRACT

TITLE: A descriptive study to assess behavioural disorders among boys and girls between the age of 5-10 years at Government Middle School, Sakkayanayakkanur, Dindigul. **OBJECTIVES:** To assess the level of behavioural disorders among both gender. To find out the association between the behaviourl disorders with demographic variables like age,

gender, parent's occupation, monthly income, no.of siblings, birth order. To find out the liner regression of beavioural disorder among boys and girls with demographic variables like age,gender,occuparion,no.ofsiblings,birth order**.HYPOTHESIS**:There will be a significant association between habit disorders with demographic Variable like age, gender, parents occupation, monthly income, no. of siblings, birth order, There will be a significant association between conduct disorders with demographic variable like age, gender, parents occupation, monthly Income, no. of siblings, birth order , There will be a significant association between emotional disorder with demographic variable like age, gender, parents occupation, monthly income,no.of siblings, birth order. **RESEARCH METHODS:** It was a Quantitative Approach. This study aims to assess the behavioural disorders among boys and girls between the age of 5-10 years at Government Middle School, Sakkayanayakkanur, Dindigul.The design adopted was Descriptive research design Conceptual frame work based on was adopted for fish born model. Total number of 60 samples of school children aged between 5-10 years, at sakkayanayakkanur, Dindigul.The instrument consisted of two sections. First section comprises of demographic variable, like age, gender, occupation, income, no. of siblings, birth order. Second section comprises to assess the knowledge on behavioural disorders it consists of 3 items. **RESULT:** Regarding age, 25 (41.7%) were between the age group of less than7 yrs, 35 (58.3%) were between the age group of 7-10 years. Regarding gender, 34(56.7%) were males, and 26 (43.3%) were females. Regarding occupation, 7(11.7%) were government employees, 30 (50.0%) were self employed, 23 (38.3) were private employees. Regarding family income, 41(68.3%) were less than 5000/month, 18 (30.0%) were 5000-10,000/month, above 10,000/month. Regarding number of siblings 31 (51.7%) were with one sibling, 24 (40%) were with two siblings, 5(8.3%) were with more than two. Regarding birth order, 27(45%) were 1st child, 27(45%) were 2nd child and 6 (10.0%) were 3d child of the family.**CONCLUSION:** Major behavioural problems are

the significant deviations from socially accepted normal behavior. These problems are mainly due to failure and adjustment to external environment and presence of internal conflict. Behavioural problems always special attention. The Present study was aimed to evaluate the knowledge on behavioural disorder and to identify the prevalence of specific characteristic behavior such as inattention/ over activity, habit disorder, conduct disorder, emotional disorder among school children.

CHAPTER I

INTRODUCTION

"Children are the wealth of tomorrow,

take care of them if you wish to have a strong

India, everyday to meet various challenges".

-Jawaharlal Nehru.

BACKGROUND OF THE STUDY

Normal children are healthy, happy and well adjusted. This adjustment is developed by providing basic emotional needs along with physical and physiological needs for their mental well being. The emotional needs are considered as emotional food for healthy behavior. The children are dependent on their parents, so parents are responsible for fulfillment of the emotional needs. Every child should have tender loving care and sense of security about protection from parents and family members. They should have opportunity for development of independence, trust, confidence and self respect. There should be adequate social and emotional interaction with discipline. The child should get scope for self expression and recreation. Parent should be aware of about achievements of their children and express acceptance of positive attitude within the social norms.

As children move in to the pre-school years (ages 2 ½ to 5 ½), cries of "No" and "I will do it myself" are frequently heard. Children this age may be easily frustrated when faced with limits. They will cry, throw tantrums and even lash out a parent, caregiver or friend. However some pre-schoolers show even more extreme and difficult behaviors, often defying adults and deliberately hurting other people. Some may be so disruptive that they are banned from pre-school. Major behavioural problems are the significant deviations from socially accepted normal behavior. These problems are mainly due to failure and adjustment to external environment and presence of internal conflict. Behavioural problems always special attention.

Children are the future of our country. They are the future citizens. So the future of every society or country depends on its children. There are various stages in growth and development of a child. The period of 1 to 3years of age is known as toddler.

The family is the central focus in the life of the toddler. The toddler in turn exerts considerable influence on all other family members, regardless of the size and form of the family unit. During this time the individual emerges from the total dependency of infancy into beginning independence or autonomy. The toddler who learned to trust the parents during infancy now can use this trust in exploration and investigation of a world beyond the parent's arms.

The parents must learn to accept the changes – physical, emotional, social and intellectual – that occur as their toddler grows and develops. The toddler needs continuing love and respect to develop a sense of security and belonging. It is essential that the behavioural standards imposed are those that the child between 1 and 3 years of age can realistically meet.

Three distinct words nature, human and habit are very much related to each other. As elders always say; nature has the habit of changing always and humans have the habit of always developing. Proceeding with this thought we could say that due to these habits human generation is existing in the earth with all these developments although we have many other factors to point out, still in or out always we can see the shadow influence of habit.

So what is this habit? In layman's talk, habit is an action which a person continues to do without any hesitation and mistake. Most of the habits are highly individualistic. But when a

habit develops it can be in either way- good or bad, long term or short term. But as a social being we always try to possess good habits and that will be there for life long. Also when we think of bad habit/habit disorders, we must consider one thing that habits can be good or bad according to attitude of the person and society and culture of the community.

Habits begin for a variety of reasons. Ultrasonography has given us a window into the prenatal life of the foetus. Even before birth the foetus may be seen seeking comfort by sucking a thumb. This self-soothing behaviour becomes habituated and may continue for many months or years.

Childhood habits appear in many different forms. Many people engage in some degree of habit like behaviour in their lifetime.

There are also health effects. Finger or thumb sucking may result in orthodontic and speech problems. People who pick at scabs or bite their fingernails may develop skin infections. About half of individuals with trichotillomania will put the hair in their mouth. Some swallow it which can result in a trichobezoar and intestinal obstruction. Those with tic disorders may be placed on medications that can have significant side effects. Certainly there are a multitude of health problems associated with smoking, chewing tobacco and eating disorders.

Some of the habit disorders which we commonly observe are:-

- Thumb sucking
- Nail biting
- Hair pulling

- Nose picking
- Bruxism / teeth grinding
- Head banging

Emotional and behavioural problems in children are common. Research suggests that parenting has an important role to play in helping children to become adjusted and that the 1st few months and years of a child's life are especially important in establishing patterns of emotional, cognitive and social functioning which will in turn influence the child's future development and in particular, their mental health. The finding of this review provides some support for the use of group-based parenting programmes to improve the emotional and behavioural adjustment of children under the age of 3 years. Parenting programmes may therefore have a role to play in improving the emotional and behavioural adjustment of infants and toddlers.

The behavioural characteristics commonly observed during the toddler period include negativism, temper tantrums, ritualistic behaviour, and ambivalence. These are manifestations of the child's efforts to assert autonomy. Some of the common behavioural problems in children are resistance to feed or impaired appetite, breath holding spell, temper tantrums, thumb sucking, nail biting, masturbation, unclear speech, stuttering, pica, sleep disturbances, enuresis, encopresis, etc. Most of the problems are minor and do not cause permanent disturbances. Nevertheless, these cause anxiety considerably to the parents.

Since, children show a wide variety of behavioural disorders, management of these minor behaviour deviations require an understanding of the stresses which lead to these

problems. So giving education to the parents regarding the common behavioural problems of children will help them in better management of these problems in future.

NEED FOR THE STUDY

"Knowledge is like a garden; if it is not cultivated it cannot be harvested"

Some childhood habits remain unnoticed and can persist untreated, even when they interfere with the child's optimal functioning. Childhood habits can result in negative social interactions and avoidance by peers and family members. Some repetitive behaviour can cause damage. For example, teeth grinding (Bruxism) can result in tooth damage. Occasional hair pulling can result in hair loss or evolve into the more severe disorder, trichotillomania. However, for most children who are otherwise developing normally, few habits result in permanent physical damage to the child. In some cases, treating a childhood habit before clear-cut dysfunction arises may prevent serious psychopathology and social dysfunction. Much of what is known about childhood habits derives from the literature about common habit behaviours in adults.

A study was conducted to determine the prevalence of attention deficit hyperactivity disorder and co-morbid conditions among 1112 school students aged 6-12 years in Nigeria. The result showed that the prevalence of attention deficit hyperactivity disorder (ADHD) was 8.7%, sub type were predominantly inattentive 4.9%, predominantly hyperactive/ impulsive 1.2%, and combined type is 2.6%, the male to female ratio was 2:1 for all the sub types. The co morbid conditions include oppositional defiant disorder (ODD- 25.8%), conduct disorder 9.3%.

Studies says accurate prevalence rates of childhood habits are extremely difficult to estimate because of the various classes of habits and the differing topographies of a child's presenting habit. The prevalence rates of habit disorders are at best unclear, and some remain unknown among children.

Estimates from the literature for various types of common habit disorders appear below.

- ≈ **Thumb sucking**: This is common in infancy and in as many as 25-50% of 2-year-old children. However, it is observed in only 15-20% of 5- to 6-year-old children.
- ≈ **Nail biting**: This is mainly observed from pre-school age to adolescence; the prevalence is as high as 45%-60%.
- ≈ **Nose picking**: Few studies have been performed. In that 91% of adults reported nose picking.
- ≈ **Teeth grinding**: This is observed in 5-30% of children.
- ≈ **Head banging**: This can occur in 3-19% of developmentally normal children younger than 3 years.

A study was conducted to identify the prevalence of specific characteristic behaviour such as inattention/ over activity among 9,299 school students at Sweden. A random technique was used. The findings were 5.7% of them had a symptom of hyperactivity, 2.3% of attention deficit hyperactivity disorder(ADHD), 3.6% of conduct disorder(CD) and another 3.0% for mixture of attention deficit hyperactivity and conduct disorder.

Conduct or behaviour problems include problems related to repeated violation of other's rights, aggressiveness, hyperkinetic impulsive behaviour, and missing classes or running away from school. The Global Burden of Disease report 2010 indicates that conduct disorder is among the 15 leading causes of disability adjustment life years of children ages 5–19 years. A study conducted in five developing countries suggest that 10.5 % of adolescent

suffer from mental health problems, with significant proportion being conduct problems. Likewise, 20.8 % of children in Brazil, 11.7-13.7 % of school age children in Sri Lanka, 34-36 % of children in Pakistanand 30 % of children in India suffer conduct or behavioural problems.

A study was conducted to determine the prevalence of behavioural problem in 957 school children of Ludhiana, India. The result showed that 45.6% of the children were estimated to have behavioural problems, of which 36.5% had significant problems. Conduct disorders (5.4%) Hyperkinetic syndrome (12.9%) scholastic under achievement (17%) and enuresis (20.3%) were detected to be the main problems in children.The study concluded that behavioural deviance does exist in our children.

According to Indian Council of Medical Research 2009, overall prevalence of mental and behavioural disorder in Indian children to be 12.5%. Studies conducted in rural and urban areas of different parts of India suggest prevalence of behaviour disorder ranges from 1.6%-41.3%.

A study was conducted on behavioural problems among pre-school children in Salem, Tamilnadu. The findings of the study reveals that, the level of behavioural problems among 50 pre-school children of employed mothers, 33 (66%) of them had moderate behavioural problems and 17 (34%) of them had mild behavioural problems. Whereas among 50 pres-chool children of unemployed mothers, 11(22%) of them had moderate behavioural problems and 39(78%) of them had mild behavioural problems. The study finding shows that behavioural problems are found high among pre-school children of employed mothers than the pre-school children of unemployed mothers.

The above statistical information and review of literature indicates that the prevalence rate of habit disorders in childhood are increasing which provoke the researcher to do this

study. In this study the researcher will assess the behavior disorder among the school children and will be developing an information booklet which will be helpful in the future for the school teachers and school authorities to help the children by early identification and referral services.

STATEMENT OF THE PROBLEM

A descriptive study to assess the behavioural disorders among boys and girls between the age of 5-10 years at Government Middle School, Sakkayanayakkanur, Dindigul.

OBJECTIVES OF THE STUDY

1. To assess the level of behavioural disorders among both gender.

2. To find out the association between the behavioural disorders with demographic variables like age, gender, parent's occupation, monthly income, no.of siblings, and birth order.
3. To find the linear regression of behavioural disorders among boys and girls with demographic variables like age, gender, parents occupation, monthly income, no. of Siblings, Birth order.

HYPOTHESIS

H_1: There will be a significant association between habit disorders with demographic variable like age, gender, parents occupation, monthly income, no. of siblings,and birth order.

H_2: There will be a significant association between conduct disorders with demographic variable like age, gender, parents occupation, monthl income, no. of siblings, and birth order.

H_3: There will be a significant association between emotional disorder with demographic variable like age, gender, parents occupation, monthly income,no.of siblings, and birth order.

OPERATIONAL DEFINITION

ASSESS : To evaluate or analyze.

BEHAVIOUR : A response of an individual or group to an action environment, person or situation.

DISORDERS : An abnormal physical or mental condition.

HABIT DISORDER : A habit is a learned pattern of behavior that is repeated so often that it becomes automatic often there is a particular stimulus, or trigger that activates the automatic behavioural response.

CONDUCT DISORDER: It is a serious behavioural and emotional disorder that can occur in children and teens. Conduct disorder is a repetitive and persistent pattern of behavior in children and adolescent in which the right of others or basic social rules are violated.

BOYS : A male child, from birth to full growth, especially one less than 18 years of age.

GIRLS : A female child, a young or relatively immature young woman, especially formerly, an unmarried one.

MIDDLE SCHOOL : A school at a level between elementary and high school, typically including grades five or six through eight.

ASSUMPTIONS:

1. Some school children may have behavioural disorders like habit disorder, conduct disorder, and emotional disorder.

2. It may enhance to assess the early detection and management of childhood behavioural disorders.

DELIMITATIONS:

1. The samples were limited to school children.
2. The sample age group is 5-10 years.
3. Data collection period is 4 weeks
4. The sample size is 60 school children.

CHAPTER II

REVIEW OF LITERATURE

INTRODUCTION:

For research study review of related literature is an essential of feature of investigation. The Substantial use of published related literature is involved in most of the research work. In fact the ability to rummage and search out obscure facts and figures is often considered as a basic activity of any researcher who should demonstrate skill and ability to make correct use relevant related literature properly.

The researcher requires sufficient familiarity in the area of choice of work. “The survey of related study implies locating studying and evaluating reports of relevant researchers”. The previous research study materials are abstract and most important writing of authorities in the field under study is reviewed.

The phrase learning disability came out from a necessity for identifying and serving children affected by leaning disorder to describe children having serious problems of leanings in school but do not come under any categories of handicap. Mr. Samuvel Kirk coined the phrase disability

Review of literature consists of 4 parts.

PART I : Literature related to Behavioural disorders
PART II : Literature related to Habit disorder
PART III : Literature related to Conduct Disorder
PART IV : Literature related to Emotional Disorder

PART I: LITERATURE RELATED TO BEHAVIOUR DISORDER

Studies conducted in Indian context:

Numerous studies the various research studies conducted in relation to Behaviour disorder in Indian context are presented below:

The National Health Interview Survey (NHIS) in 2001. The NHIS assesses close to 50 000 families containing a total of approximately 10 000 youth (ages 4 to 17) each year. With the exception of pervasive developmental disorders, there has been considerable controversy about the validity of diagnosis of mental disorders in very young children (ages 2 to 5 years). There is accumulating evidence, however, that mental disorders generally identified in school-age children are quite prevalent in preschool children. In a summary of the community surveys of young children, Logger and colleagues 98 reported the following range of rates of childhood disorders: ADHD from 2% to 5.7%; ODD from 4% to 16.8%; CD from 0% to 4.6%; depression from 0% to 2.1 %; and anxiety disorders from 0.3% up to 9.4%. In addition to the prevalence of these disorders in young children, rates of impairment are very high (ie, about 84.6% of those with emotional disorders and 100% of those with behavioral disorders). There is also a high degree of co morbidity in young children with

mental disorders; of those with one disorder, approximately 25% have a second disorder. The proportion of children with co morbidity increases about 1.6 times for each additional year from age 2 (18.2%) to 5 (49.7%).98

Gupta, Indira, et al. (2001). Prevalence of behavioural problems in school going children. Indian Journal of Paediatrics. A large number of children suffer from behavioural problems at one time or the other during their growing up years. The present study was conducted on 957 school children aged 5-11 years from an urban area of Ludhiana, India to assess the prevalence of behavioural problems. The study was conducted in two stages. In the first stage, a screening instrument Rutter B Scale was used to detect common emotional, conduct and behavioural problems in children. The responses were scored as 2,1, and 0 respectively. 141 children scored more than 9 points and were included in the second phase of the study. Equal number of sex matched children scoring less than 9 points served as controls. Both the groups along with their parents were interviewed by a child psychiatrist. Only 117 and 124 children turned up and were included in the analysis. Based on the screening instrument results and parents' interviews, 45.6% of the children were estimated to have behavioural problems, of which 36.5% had significant problems. Conduct disorders (5.4%), Hyperkinetic syndrome (12.9%), scholastic under-achievement (17%), and enuresis (20.3%) were detected to be the main behaviour problems in children. Health education and counselling of parents especially fathers should be made available close co-operation between school teachers, parents, and health care providers is suggested to ensure healthy development of children.

Salman Bandeali, Ahmed Jawad, AsmaAzmatullah, Medical Students, Aga Khan University, Karachi.2006.

A cross sectional study was conducted in three urban squatter settlements of Karachi from May to June 2006, targeting working children aged 5-16 years. Behavioural problems of these children were estimated by using the self reported Urdu version of the Strengths and Difficulty Questionnaire. Out of a total of 225 respondents, 94.2% (n=212) males and 5.8% (n=13) females, the prevalence of Behavioural Problems among working children was found to be 9.8%. Peer problems were most prevalent (16.9%) seconded by Conduct problems (16.7%). Adverse family environment and work environment were closely associated with Behavioural Problems in these children followed by conduct problems (16.7%) and emotional problems (12.0%). The mean scores were 2.97, 2.55, and 3.35 respectively. Among the individual problems, emotional problems were most prevalent in children with a disturbed family environment (p=0.004) . . A high frequency (38.3%) of peer problems were found in those children who had been working for less than a year as compared to 14.9% who had work experience of more than five years (p=0.041).

Trautmann-Villalba P, Gschwendt M, Schmidt MH, Laucht M. (2006)

A study was conducted to identify the prevalence of specific characteristic behavior such as inattention/ over activity among 9,299 primary school students at Sweden. A random technique was used. The findings were 5.7% of them had a symptom of hyperactivity, 2.3% of attention deficit hyperactivity disorder (ADHD), 3.6% of conduct disorder (CD) and another 3.0% for mixture of attention deficit hyperactivity and conduct disorder.

Baum KT, Byars AW, deGrauw TJ, Johnson CS, Perkins SM, Dunn DW. et al. (2007) identified children with exhibit relatively high rates of behavioural problems. A study was conducted to compare the level of behavioral problems among pre-school children of 100 employed and unemployed mothers in Bangalore. The result showed that 50 pre-school

children of employed mothers 33 (66%) of them had moderate behavioral problems (17%); 34 of them had mild behavioral problems and none of them had severe behavioral problems. The study concluded that there is a significant association between the levels of behavioral problems with age of the child, religion, grade of the child, religion among preschool children of employed mother with their selected demographic variables.

JyotiPrakash, A.K. Mitra, H.R.A. Prabhu,Department of Psychiatry, Military Hospital, Delhi. APRIL 2008.

A school based study, 50 children of age 6-14 years attending government school were assessed for behaviour problems. Children were selected after appropriate randomization and subsequently assigned to Child behaviour checklist. The data thus collected was suitably interpreted using appropriate statistical tests. Twenty-one (42%) children were found to be above the cut-off score. Mean CBCL score was 43.3. Most common behaviour problems in these subjects were “can not sit still, restless, hyperactive” shown by 62% of the subjects. Twenty-one (42%) children were found to be above the cut-off score. Mean CBCL score was 43.3 (SD+27.17). Of the fifty children studied thirty-six children (72%) were from the Armed forces background. Four (8%) out of the total 50 children were officer’s children. Manage of the study population was 9.9 years (SD+2.69years). Male to female ratio was 1:1. There was no significant difference in the prevalence of behaviour problems between age group 6-11 years and 12-14 years. Sex-wise distribution showed no significant difference in prevalence of behaviour problem. “Too concerned with neatness or cleanliness” (60%) and “demands lot of attention”(56%).

Klinnert MD, Kaugars AS, Strand M, Silveira L. (2008) A study was conducted to

determine the prevalence of behavioural problem in 957 school children of Ludhiana, India. The result showed that 45.6% of the children were estimated to have behavioral problems, of which 36.5% had significant problems. Conduct disorders (5.4%) Hyperkinetic syndrome (12.9%) scholastic under achievement (17%) and enuresis (20.3%) were detected to be the main problems in children. The study concluded that behavioral deviance does exist in our children.

Brandon A. Kohrt and Mark J.D. Jordan's (2008)A clinical trial of mental in children with behavioural problems was conducted at the S.N. Children's Hospital, Allahabad on 105 children whose age ranged from two to five years, suffering from various behavioural problems comprising of nocturnal enuresis, speech defects, pica, learning disability, school phobia, temper tantrums, breath-holding spells and thumb-sucking. The result showed that marked improvement was seen in children with nocturnal enuresis, pica and breath-holding spells with mild improvement in school phobia, learning disability and speech defect. In cases of pica, apart from mental administration the parents were given counselling and the cases received haematinics and nutritional additives. Improvement was seen in eighteen cases 90% of which fourteen 70% showed marked improvement and four cases mild improvement. The maximum incidence was in the two to five years' age group (40%). Simultaneous improvement in intelligent quotient was seen in ten cases 50% with marked improvement in 10% and mild in 40% of cases. The study concluded that mental holds out promise in the treatment of certain behavioural problems and further extensive trials are desired.

Dr. Sandip S Jogdand , Associate Professor, Department of PSM, Rural Medical College, Loni .(2013.)

Total 600 parents of children in the age group of 6-18 years were selected by simple random sampling method using random number table from the family register. The

information regarding behaviour was recorded in pretested questionnaire. Antisocial problems like lying; stealing; gambling; destructiveness and fire setting habit problems thumb sucking; nail biting; enuresis; tobacco use; alcohol consumption; other non-medicated drug use Personality problems jealousy; temper tantrum; fear; shyness; anxiety psychosomatic problems headache; hallucination; tremors; depression. Educational difficulties Frequency (%) Educational 172 (57.72) Antisocial 127 (42.62) Personality118 (39.60) Habit 93 (31.20)). In the present study male preponderance was observed for educational difficulties ($x2= 8.2$, $p < 0.05$); antisocial problems ($x2= 8.91$, $p < 0.05$) and habit problems ($x2= 18.23$, $p < 0.001$). Educational difficulties were observed prevalent amongst lower age group i.e.612yrs ($x2= 4.58$, $p < 0.05$) while antisocial problems were observed prevalent amongst higher age groups.

PART II: LITERATURE RELATED TO HABIT DISORDER

Gupta, Indira, et al. (2001). Prevalence of behavioral problems in school going children. IndianJournal of Pediatrics. A prospective clinical study was conducted to observe the various aspects of clinical profile of pica in Jammu, India**.** The study was conducted at a pediatric clinic among indirect history of pica. These children were compared to that of 100 non-pica children aged two to four years. The results showed that 64% of cases with a direct or indirect history of pica belonged to two to four years of age group and there was a definite male predominance (M: F- 1.5: 1). Poor nutritional status (46%) and intestinal parasites (63 %) were identified in children with direct history of pica. Initial hemoglobin levels were less than eight grams/deciliter in 34.5 % and 11 grams/deciliter or greater in 20 % of pica children compared with 12 % and 56 % respectively in control children.The researcher concluded that pica is more common in childhood and the major contributing factors resulting in pica are the short family size, the working mothers and bottle-feeding. The

children who practice pica are prone to malnutrition, anemia, diarrhea, constipation and worm infestation. Geophagy is the most frequently observed pica and there is often a family history of pica.

Potegal M, Davidson RJ. (2003) conducted a study on temper tantrums in young children. Although tantrums are the most common behavioural problems of young children, they may predict future antisocial behaviour. They also identified anger and distress as major independent emotional and behavioural tantrum constituents. A cross sectional study was conducted on parents especially mothers knowledge regarding reinforcement technique for temper tantrum among parents of 132 children (101 mothers, 31 fathers) in Finland. The result showed that 64.7% began having tantrums when they were 2 or 3 years old; 57.1% did not have tantrums anymore after age five. The study concluded that there was no sex difference for age of onset of tantrums and parents can control the tantrums with reinforcement technique. So parental education is important for using reinforcement technique.

Egerton, Kenya (2005) A cross sectional study was conducted to assess the association of geophagy with anemia and iron status among primary school children in Western Kenya. The method used was qualitative assessment based on structured interview among 156 primary school children (median age 13 years, range) Hemoglobin levels were determined in all 156 children and serum ferritin concentrations in 135. The results indicated that 114 (73.1%) of these children reported eating soil daily. Both the anemic and iron-depleted children were significantly higher among the geophageous children than among the non-geophageous. Eleven children (seven percent) were anemic and twenty (14.8%) children were iron depleted. Parasitic infections were found more among geophageous children .The researcher concluded that iron depletion and anemia are associated with geophagy. Further studies and

iron supplementation intervention studies have to be conducted to find out the causal relationship between geophagy and iron status and anemia.

Tervo RC. (2007) A study was conducted on the attitudes of Saudi mothers towards the digit sucking habit in their children and their attempts to stop this fixation in Department of Preventive Dental Sciences. The results shown that 48 mothers did not like to see the habit at any age. Most mothers (86%) tried to stop their children digit sucking. 66% of the present sample and noticed the adverse effect of this fixation on their child's occlusion, and this was given as the main reason for their attempts to stop the habit. The study concluded that the majority of mothers have noticed the adverse effect of the digit suck.

PART III: LITERATURE RELATED TO CONDUCT DISORDER

SujitSarkhel, Vinod Kumar Sinha, Manu Arora, and PushpalDeSarkar Author information, Indian J Psychiatry. 2006 Jul-Sep; Prevalence estimates of conduct disorder, one of the most frequently diagnosed psychiatric conditions in children, vary widely from 0.2% to 8.7%. To find out the prevalence of conduct disorder and its DSM-IV subtypes and co morbid attention deficit hyperactivity disorder (ADHD) in 4 schools of Kane block among students of classes V to X. A total of 240 students, selected by stratified random sampling, were subjected to the Schedule for Affective Disorders and Schizophrenia for School Age Children: Present and Lifetime Version (K-SADS-PL) screening interview. Nineteen students who qualified were subjected to conduct disorder and ADHD supplement of K-SADS-PL with additional information from parents. Conduct disorder was found in 4.58%; the ratio of boys to girls being 4.5:1. Childhood onset was found in 73% and adolescent onset in 27%. Mild conduct disorder was found in 36%, moderate in 64% and severe conduct disorder in none. Co-morbid ADHD was found in

36%, hyperactive-impulsive being predominant. Significant difference was found in temperament between students with and without conduct disorder with difficult temperament predominating in the former and easy in the latter (p=0.004). Lying, bullying and cruelty to animals were most frequent symptoms. The prevalence of conduct disorder was 4.58%, more common in boys, the majority had childhood onset, and one-third had co morbid ADHD. Among Indian studies, Deivasigamani has reported the prevalence of CD to be 11.13%, Sarkar et al. reported the prevalence rate of antisocial behaviour to be 7.1% while recently Spinach et al. have reported prevalence as low as 0.2%. ADHD is common co morbidity in children with conduct disorder.

Nimisha Mishra1, Ambrish Mishra2, Rajeev Dwivedi, 2015, February, Volume: 4

To identify the prevalence of CD in primary school children, to identify the gender difference in the prevalence of CD. This is a cross sectional study of school aged children selected from four different schools in Rewa district. Nine hundred children aged between 6- 11 years were selected from different four schools in Rewa district after obtaining informed consent from their parents and the school authorities. Statistical Product and Service Solutions (SPSS) 10 software Mean and Standard Deviation, and chi square test were used for statistical analysis. The prevalence of CD among primary school children was found to be 5.48. Prevalence was found to be higher among the males (66.67%) as compared to that of females (33.33%). The present study shows a high prevalence of CD among primary school children with a higher prevalence among the males than the females.

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PART IV: LITERATURE RELATED TO EMOTIONAL DISORDER

Angold 2002; Canino et al. 2004; Meltzer et al. 2003. The prevalence of emotional disorders among children and adolescents can be assessed in different ways, making it difficult to compare findings from different studies different estimates for the prevalence of emotional disorders (Roberts et al. 1998). One systematic review of prevalence studies from around the world found median prevalence rates for all psychiatric disorders of 8.3% for preschoolers, 12.2% for preadolescents and 15.0% for adolescents (Roberts et al. 1998). Typically, about half or just under half of the children and adolescents in found that prevalence rates for anxiety and depression were similar in the North American and Western European countries (though Italy was somewhat lower than the other countries in this group), as well as Australia, Hong Kong, and China. Rates in Eastern European countries were higher.

MoatazM Abdel-Fatta, Abdel-RahmanA.Asal, Saeed M. Al-Asmary, From the German Journal of Psychiatry, **2004**. Determination of the prevalence rate of emotional and/or behavioral problems among male Saudi school children and identifying their possible risk factors. All male schoolchildren of Al-Apnea schools specialized for the sons of the employees of the Saudi Ministry of Defense (military and civilians) in Tariff Governorate, Saudi Arabia were included. A screening phase for all schoolchildren and adolescents included in the study through a cross sectional approach to assess their emotional and behavioral problems. A case-control phase to study risk factors. The screening phase was conducted using the Child Behavior Checklist "Parents' form "Among 1313 participated in the study, 109 (8.3%) were emotionally and/or behaviorally disturbed students (according to cut-off score for boys estimated at the 90thpercentiles). Among studied socio-demographic variables, educational level (intermediate versus primary) and mother occupation (working versus non-working) were associated with a higher risk higher risk of developing emotional and/or behavioral disturbance. Unwanted pregnancy (OR=4.77, CI: 3.68-5.86), history of

meningitis (OR=7.50, CI: 5.12-9.88), accidents (OR=4.07, CI: 2.87-5.26) and bronchial asthma (OR=2.96, CI: 2.16-3.76) had an increased risk of emotional and/or behavioral disturbance. The first phase of the study includes 1313 male Saudi school children. Their age ranged from 6 to 18 years with a mean of 11.2±2.5 years. As regards, educational level children attending primary schools were nearly two-fold those attending intermediate schools represented by 65.2% and 34.8% respectively. The majority of them have non working mothers (84.7%) and military father (85.5%). The great majority of them have either intermediate (62.4%) or high (31.4%) educated fathers and either intermediate (41.6%) or low (39.9%) educated mothers. Among 1239 investigated school children, the most common emotional and/or behavioural problems were anxiety (13.5%), Schizophrenia (11.9%) and depression (8.6%), followed by somatic disorders (7.0%), obsession (6.9%), hyperactivity (6.1%), aggression (4.0%) and finally delinquency (3.6%).

Briggs-Gowan MJ, Carter AS, Bosson-Heenan J, Guyer AE, Horwitz SM. (2006)
Examined the persistence of parent-reported social-emotional and the prevalence of emotional and behavioural problems among 1488 primary school children aged 5 to 11 years were studied in Karachi, Pakistan. Assessment of children's mental health was conducted using Strength and Difficulties Questionnaire (SDQ). The results show that 34.4% parents rated children as falling under the "abnormal category" on strength and difficulties questionnaire, 35.8% were reported by the teacher. The study concluded that there is a gender difference in prevalence.

Conceptual Frame Work:

Conceptual frame work deals with obstruction that is assembled by virtue of their relevance to a common theme a conceptual frame work broadly presents an understanding of

the phenomenon of interest and reflects the assumption & philosophical view of the models designs.

A conceptual map includes all of the major concepts in a theory or frame work. The conceptual frame work for this study is based on the health belief model. This is the most popular model among the models for health education.

Rosen stocks and Becker 1975 belief model is a way of understanding predicting and how the present will behave in relation of their health and how will comply with health care therapies.

The framework of the study is adopted from the fish bone diagram (cause & effect diagram 1992) and health belief model the fish bone diagram has develop by a group of individual from the member of a quality assurance forum, Health belief Model was proposed by Rosen stocks(1974) and Becker and main man's 1975.

It addresses the relationship between a person's beliefs and behaves as it consists of the 3 components.

- Individual Perceptions
- Modifiable Factors
- likelihood of action

INDIVIDUAL PERCEPTION:

It refers to the individual perception of susceptibility of an inners they are demographical variables which given the thoughts, feelings, and valves of the patient. They are expressed in the age, gender, place of residence, occupation these variables are represented as tail of the fish.

MODIFYING FACTORS:

Controllable and uncontrollable events on the circumstance which can be altered (or) not predicted to prevent improve sanitation latrine among adult have been classified under two headings and these Clements become the body of the fish.

THE LIKE HOOD OF ACTION:

It is the probable outcome of the analysis of the level of the importance of sanitary latrine among adult, In the current study, The detailed analysis from the questionnaire it will help in the current study, the detailed analysis from the questionnaire it will help in the formulation or in the development of a module on the tips to reduce the behaviour disorder among school children aged between 5-10 years.

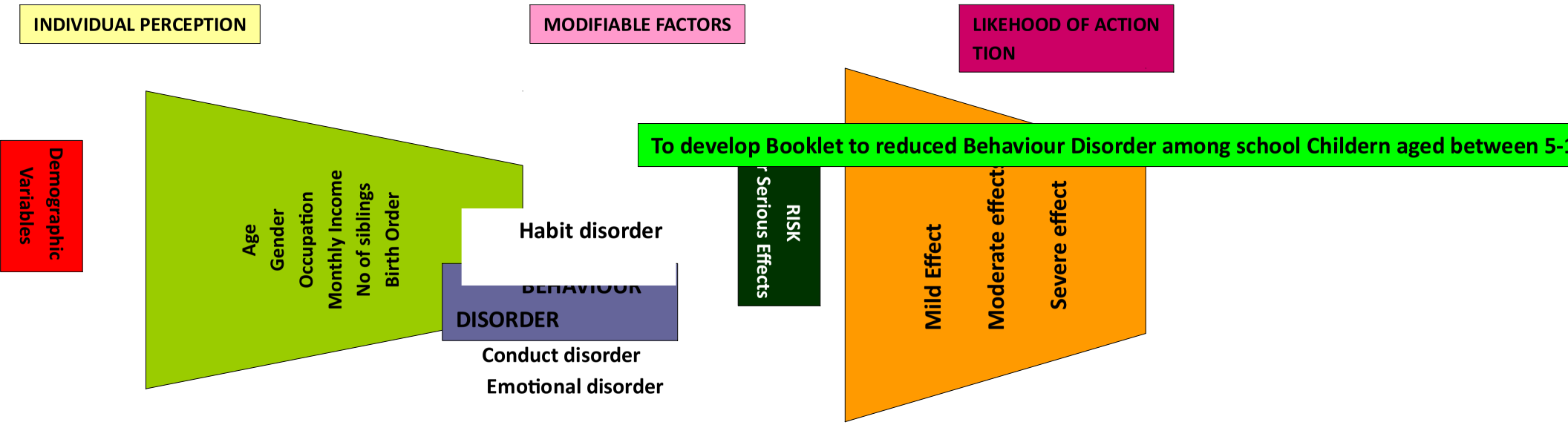


Fig - 1

Adopted from fish bone diagram cause effective diagram of Decision making and health belief model.

CHAPTER III

RESEARCH METHODOLOGY

Research methodology indicates the generalized pattern of organizing the procedure for gathering valid and reliable data for investigation. It includes the strategies to be used to collect and analyze the data to accomplish the research objective and to test research hypothesis. It includes research approach, research design, variables, the setting, the sample and sampling technique, development and description of tools, data collection and plan for data analysis.

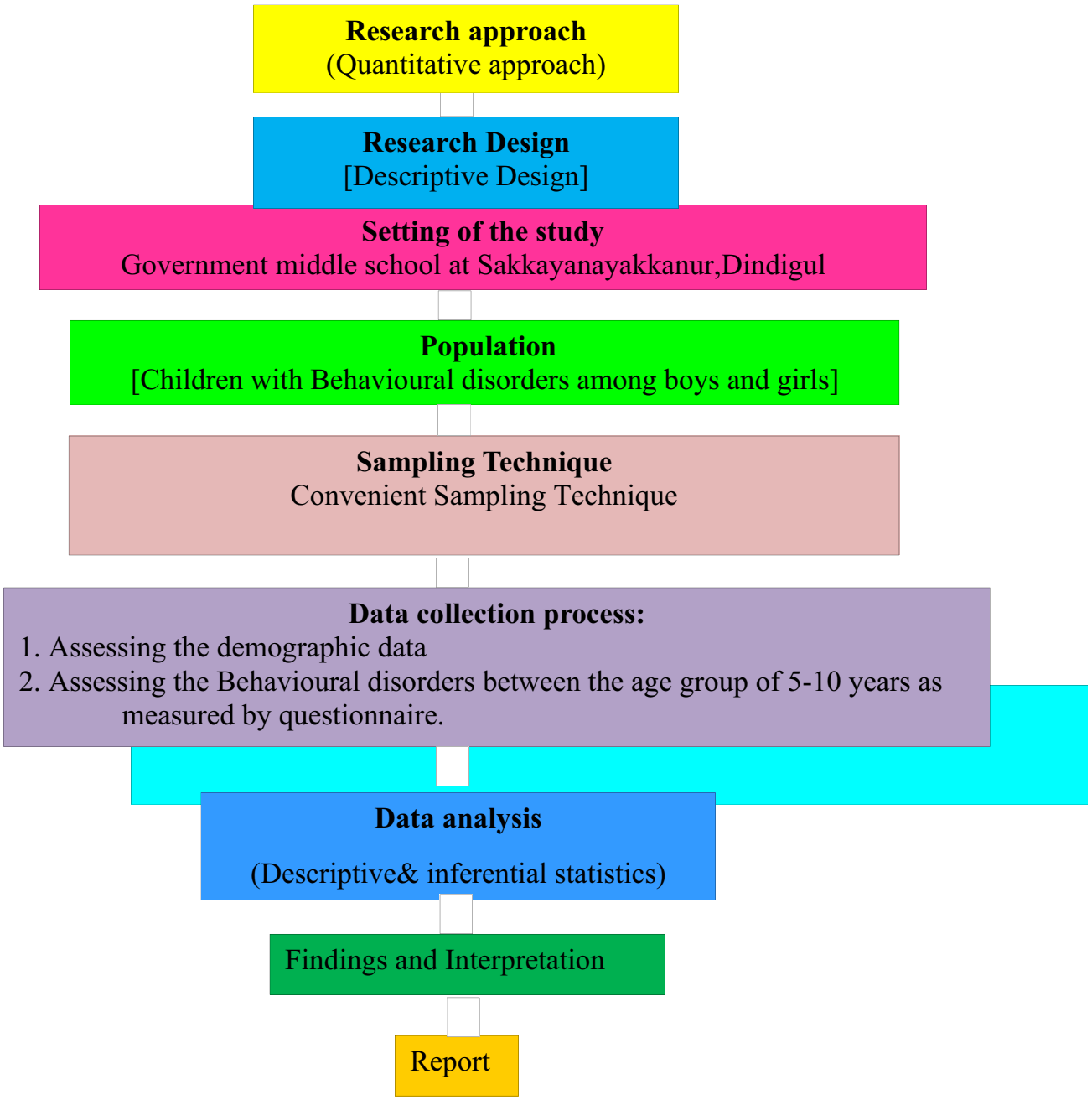
RESEARCH APPROACH

It was a Quantitative Approach. This study aims to assess the behavioural disorders among boys and girls between the age of 5-10 years at Government Middle School, Sakkayanayakkanur, Dindigul.

RESEARCH DESIGN

The design adopted was descriptive research design. This study to assess the behavioural disorders among boys and girls between the age of 5-10 years at Government Middle School, Sakkayanayakkanur, Dindigul.

Figure 2: SHEMATIC REPRESENTATION OF METHODOLOGY



VARIABLES

DEPENDENT VARIABLE

In this study dependent variables are age, gender, occupation, monthly income, no. of siblings, and birth order.

INDEPENDENT VARIABLE:

In this study independent variables are habit disorder, conduct disorder, emotional disorder.

SETTING OF THE STUDY:

The study was conducted at Government Middle School, Sakkayanayakkanur, Dindigul district.

POPULATION:

The study population consists of all boys and girls at Government Middle School, Sakkayanayakkanur, Dindigul district.

SAMPLE:

Children with who fulfilled at inclusion criteria.

SAMPLE SIZE:

Total samples are 60 children.

SAMPLING TECHNIQUE:

Sampling technique adopted for the study was Convenient sampling techniques. Convenient sampling is a type of non probability sampling method in which people are sampled simply because they are “convenient” sources of data for researchers. (Bataglia,2008).

The researcher had selected boys and girls who were available for the present study based on the inclusion criteria.

CRITERIA FOR SAMPLE SELECTION

The samples were based on the following criteria**.**

Inclusive criteria

1. Children who are interested to participate in this study.
2. Children who are available at the time of data collection.
3. Children who are able to co-operate throughout the period of the data collection.
4. Children who are able to read and write Tamil and English.

Exclusive criteria

1. Children who are having behavioural disorders.
2. Children who are psychologically and physically unfit during the time of data collection.
3. Children who are sick at the time of data collection.
4. Children who are not able to cooperate throughout the time of data collection.

DESCRIPTION OF INSTRUMENT

The instrument consist of two parts:

1. PART-1: DEMOGRAPHIC DATA

Demographic data consists of age, gender, occupation, monthly income, no. of siblings and birth order.

2. PART-2: TO ASSESS THE BEHAVIOURAL DISORDERS

To assess the behavioural disorders. It consists of 3 items. It includes habit disorder, conduct disorder, emotional disorder.

TESTING OF THE TOOLS

VALIDITY

The modified questionnaire was developed by the investigator. The tool evaluated by two experts in psychiatric nursing field, three experts in psychiatrist**.**

RELIABILITY

The investigator checked reliability of the tool was elicited by Inter rater reliability. The Tool was moderately reliable.

SCORING INTERPRETATION

SCORING FOR HABIT DISORDER:

14-18: Severe Habit disorder

9-13: Moderate Habit disorder

<9: Mild Habit disorder

0: None

SCORING CONDECT DISORDER:

9-12 : Severe Conduct disorder

6-18 : Moderate Conduct disorder

<6 : Mild Conduct disorder

1 : None

SCORING EMOTIONAL DISORDER

17-22: Severe Emotional disorder

11-16: Moderate Emotional disorder

<11: Mild Emotional disorder

0: None

PILOT STUDY REPORT

Pilot study was conducted at Government Middle School, Sakkayanayakkanur, Dindigul, for period of 1 week (5.1.2015-11.1.2015). Permission was obtained from the Headmaster of the School. **Descriptive design** was adapted to assess behavioral disorders students between the age of 5-10years at Government Middle School, Sakkayanayakkanur, Dindigul. 10% of the total population was selected. 5 Participants who met the eligible criteria were selected by convenience sampling technique. The purpose of the study was explained and written consent was obtained from each Class teachers. Behavioural disorders children between the age of 5-10years assessed by using questionnaire. The duration of data collection for each participant was 30 minutes. No problem faced during pilot study.

TECHNIQUE OF DATA ANALYSIS

Data analysis were done with the help of descriptive and inferential statistics.

SAMPLE SIZE CALCULATION

Based on pilot study sample size was calculated and 60 samples were taken for the main study.

DATA COLLECTION PROCEDURE

Written permission was obtained from the Headmaster of Government Middle School, Sakkayanayakkanur, Dindigul. The Students who fulfilled the inclusion criteria

were selected by using convenient sampling method. The researcher introduced herself to the students and developed good rapport with them for their co- operation. The researcher assured the participants for the confidentiality of their responses.

The purpose of the study was explained to every sample, so as to get their full co-operation. Adequate privacy was provided. Demographic data was collected through self report. After that assessing problems faced by students by using the questionnaire. Duration for collection of data is 30 minutes.

PLAN FOR DATA ANALYSIS

S.NO	OBJECTIVE	STATISTICAL PROCEDURE
1	To assess the level of behavioural disorders among school children	Frequency distribution and percentage
2	To find out the association between the behavioural disorders with demographic variables	Chi-Square

	like age, gender, occupation, monthly income, no. of siblings, birth order.	
3	To find out the Regression of behavioural disorders among boys and girls between the age of 5-10years.	Regression

PROTECTION OF HUMAN RIGHTS

Oral consent was obtained from the study sample before starting the data collection. Assurance was given and confidentiality was maintained.Childern who were participated in this study were explained that they have the rights to withdraw from the study at any point of time. There was absence of physical and psychological strain to the children who were participated in this study.

CHAPTER – IV

DATA ANALYSIS AND INTERPRETATION

Polit (2004) states that statistical analysis is a method of rendering quantitative information and elicits meaningful and intelligible form to research data. This chapter deals with the analysis and interpretation of the data collected and thereby to assess the "To assess the behavioural disorders among boys and girls between the age of 5-10years at Government Middle School, Sakkayanayakkanur, Dindigul." Collected data were statistically analyzed by the researcher to summarize, organize, evaluate, interpret and communicate numeric information. The collected data deals with socio demographic variables assess behavioural disorders among boys and girls between the age of 5-10 years. The data which analyzed were tabulated and presented according to the objectives of the study.

The data collected were edited, tabulated, analyzed and interpreted. The findings were organized and presented in the following orderly sections;

SECTION I: Frequency distribution and percentage on demographic variables among boys and girls between the age of 5- 10 years.

SECTION II: Frequency distribution and percentage of behavioural disorders among boys and girls between the age of 5-10 years.

SECTION III: Association between age and level of behavioural disorders.

SECTION IV: Association between gender and level of behavioural disorders.

SECTION V: Association between parents occupation and level of behavioural disorders.

SECTION VI: Association between monthly income and level of behavioural disorders.

SECTION VII: Association between number of siblings and level of behavioural disorders.

SECTION VIII: Association between birth order and level of behavioural disorders.

SECTION IX: Linear Regression on habit disorder among demographic variables.

SECTION X: Linear Regression on conduct disorder among demographic variables.

SECTION XI: Linear Regression on emotional disorder among demographic variables.

SECTION – I

FREQUENCY DISTRIBUTION AND PERCENTAGE ON DEMOGRAPHIC VARIABLES AMONG BOYS AND GIRLS BETWEEN THE AGE OF 5-10 YEARS

NO=60

Table.1 Shows that frequency distribution and percentage on demographic

S.N	DIMENSION	FREQUENCY	PERCENTAGE
1	AGE 1. <7 yrs 2. 7-10 yrs	25 35	41.7% 58.3%
2	GENDER 1. Male 2. Female	34 26	56.7% 43.3%
3	PARENTS OCCUPATION 1. Government employees 2. Self employed 3. Private employees	7 30 23	11.7% 50.0% 38.3%
4	MONTHLY INCOME 1. Rs<5000/month 2. Rs5000-10,000/month 3. RsAbove 10,000/month	41 18 1	68.3% 30.0% 1.7%
5	No. OF SIBLINGS 1.One 2.Two 3.More than two	31 24 5	51.7% 40.0% 8.3%
6	BIRTH ORDER 1. 1st Child 2. 2nd Child 3. 3d Child	27 27 6	45.0% 45.0% 10.0%

Regarding age, 25(41.7%) were between the age group of <7 yrs, 35(58.3%) were between the age group of 7-10 years.

Regarding gender, 34(56.7%) were males, and 26(43.3%) were females.

Regarding parents occupation, 7(11.7%) were government employees, 30(50.0%) were self employed, 23(38.3) were private employees.

Regarding monthly income of parents, 41(68.3%) were less thanRs 5000/month, 18(30.0%) were Rs5000-10,000/month, 1 (1.7%) aboveRs 10,000/month.

Regarding number of siblings 31(51.7%) were with one sibling, 24(40%) were with two siblings, 5(8.3%) were more than two.

Regarding birth order, 27(45%) were with 1st child, 27(45%) were with 2nd child and 6(10.0%) were 3dchild.

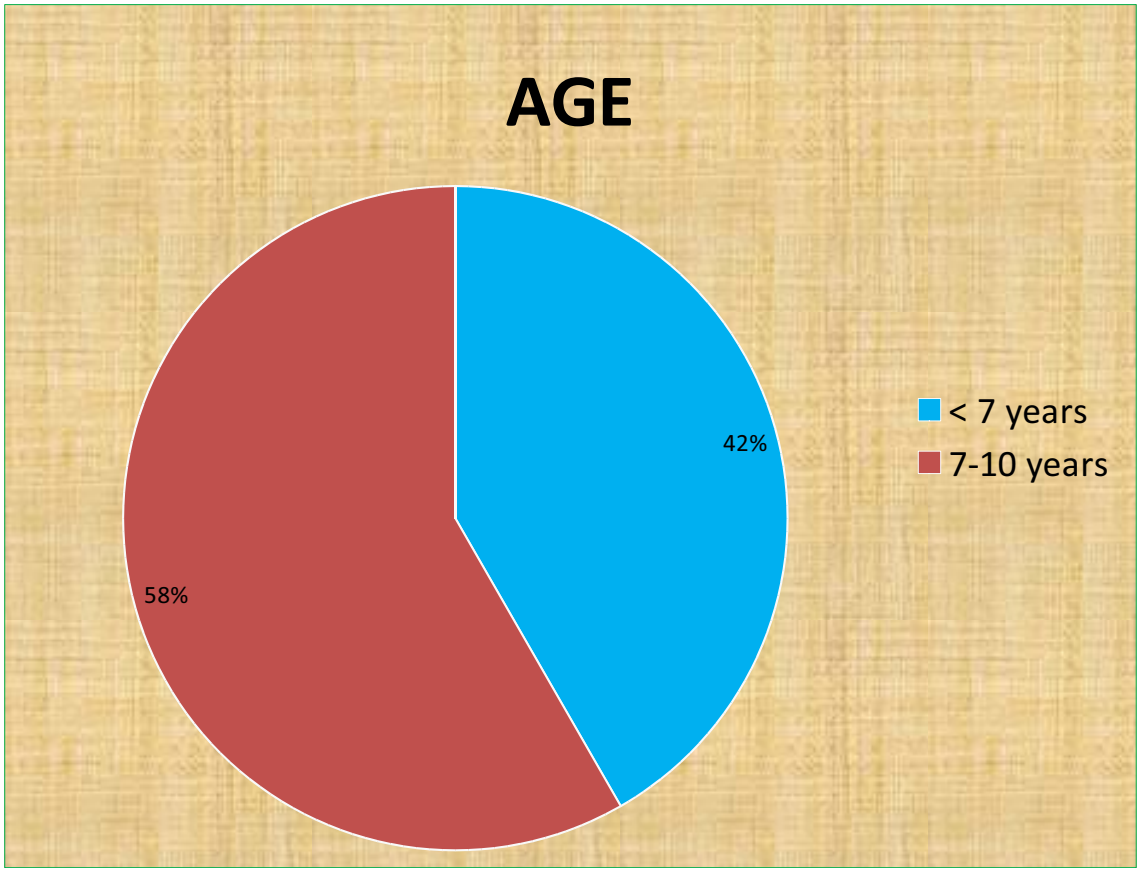


Figure: 1 Frequency distribution and percentage on Age among boys and girls between the age of 5-10 years.

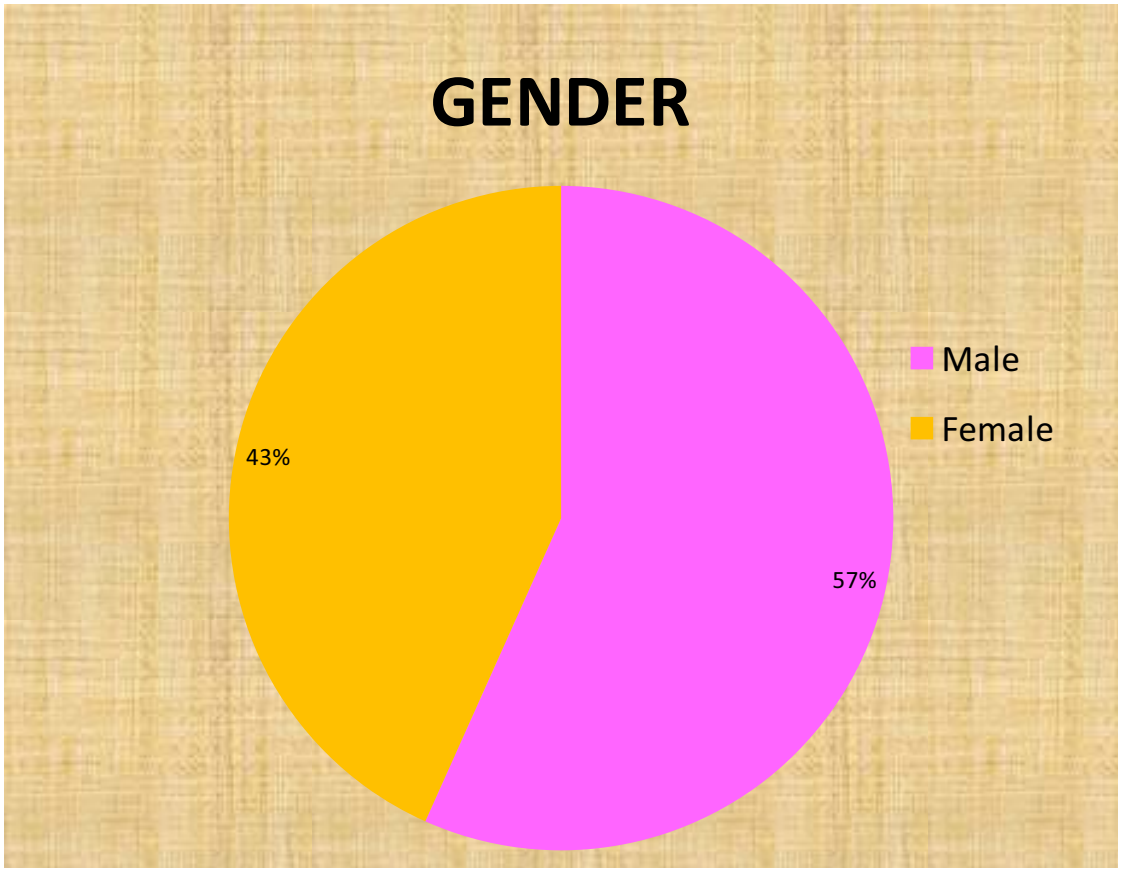


Figure: 2 Frequency distribution and percentage on gender among boys and girls between the age of 5-10years.

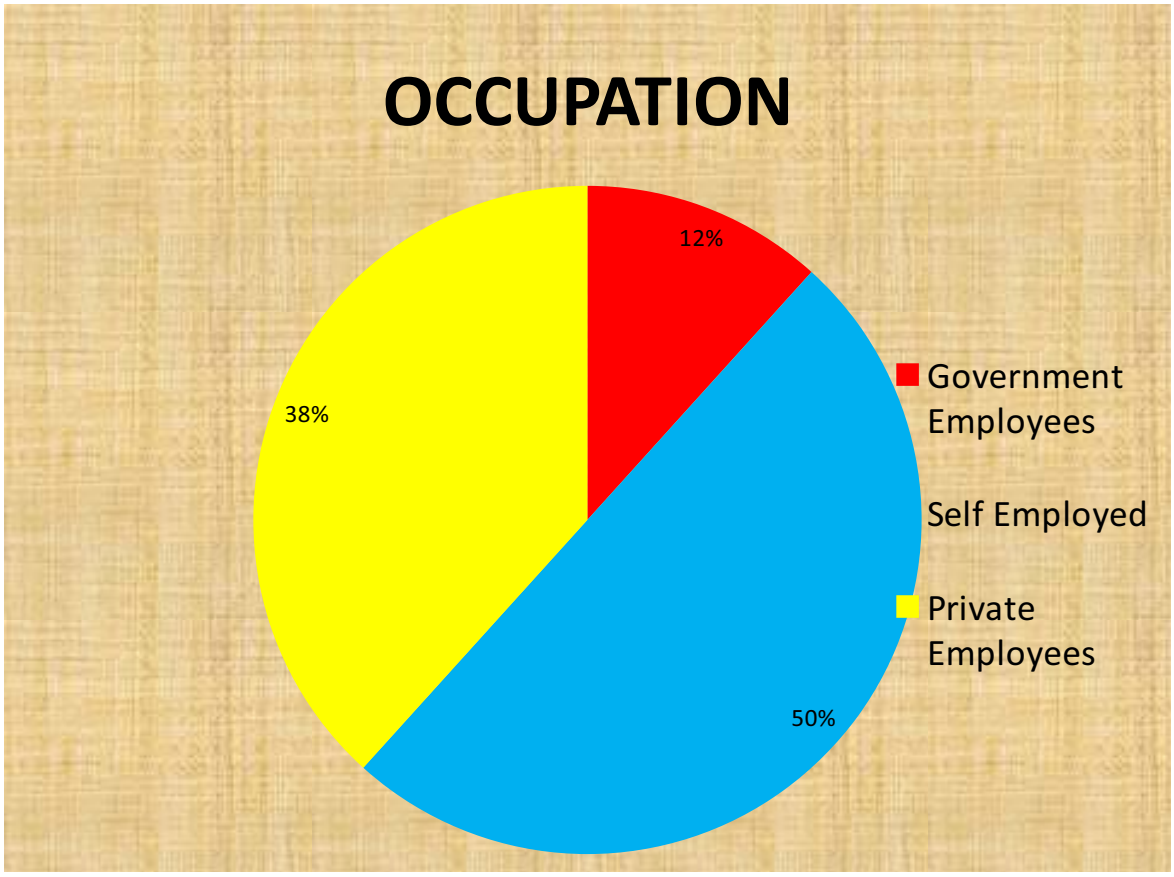


Figure: 3 Frequency distribution and percentage on parents occupation among boys and girls between the age of 5-10 years.

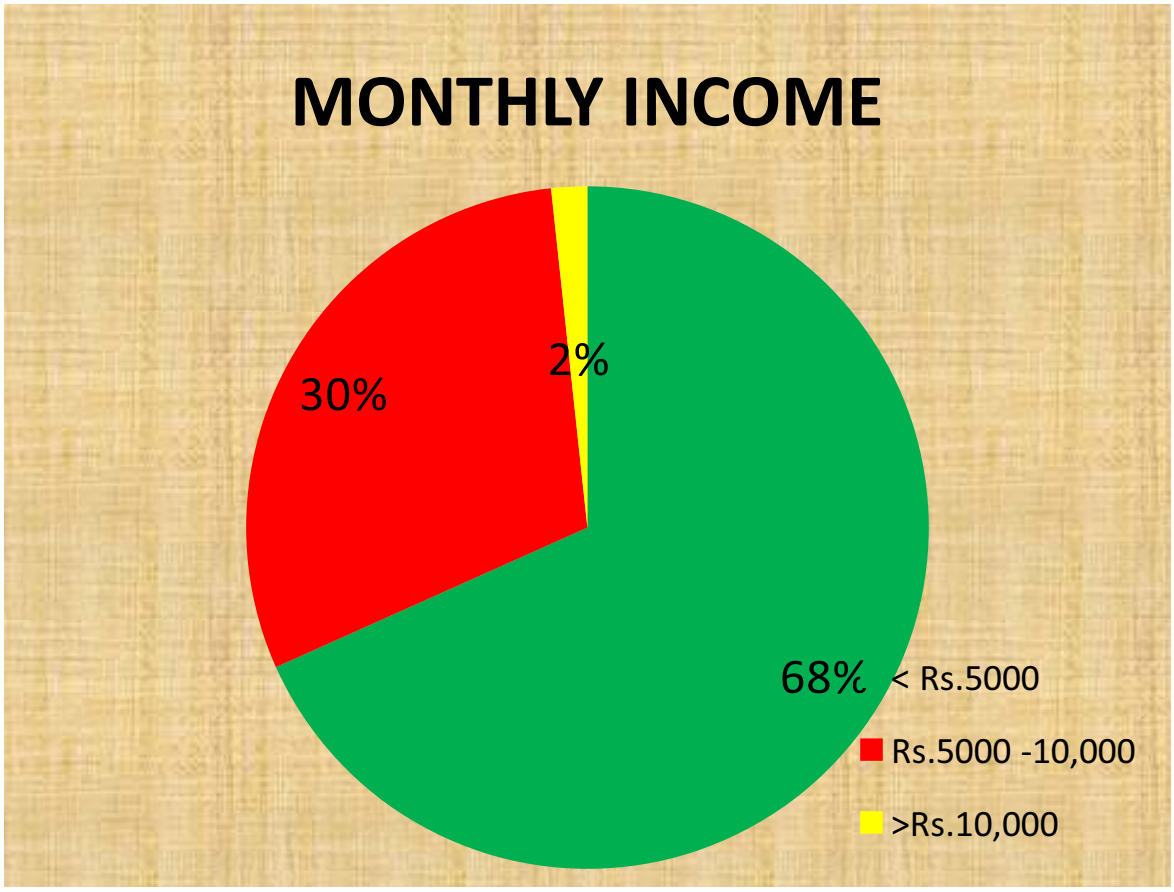


Figure: 4 Frequency distribution and percentage on monthly income of parents among boys and girls between the age of 5-10 years.

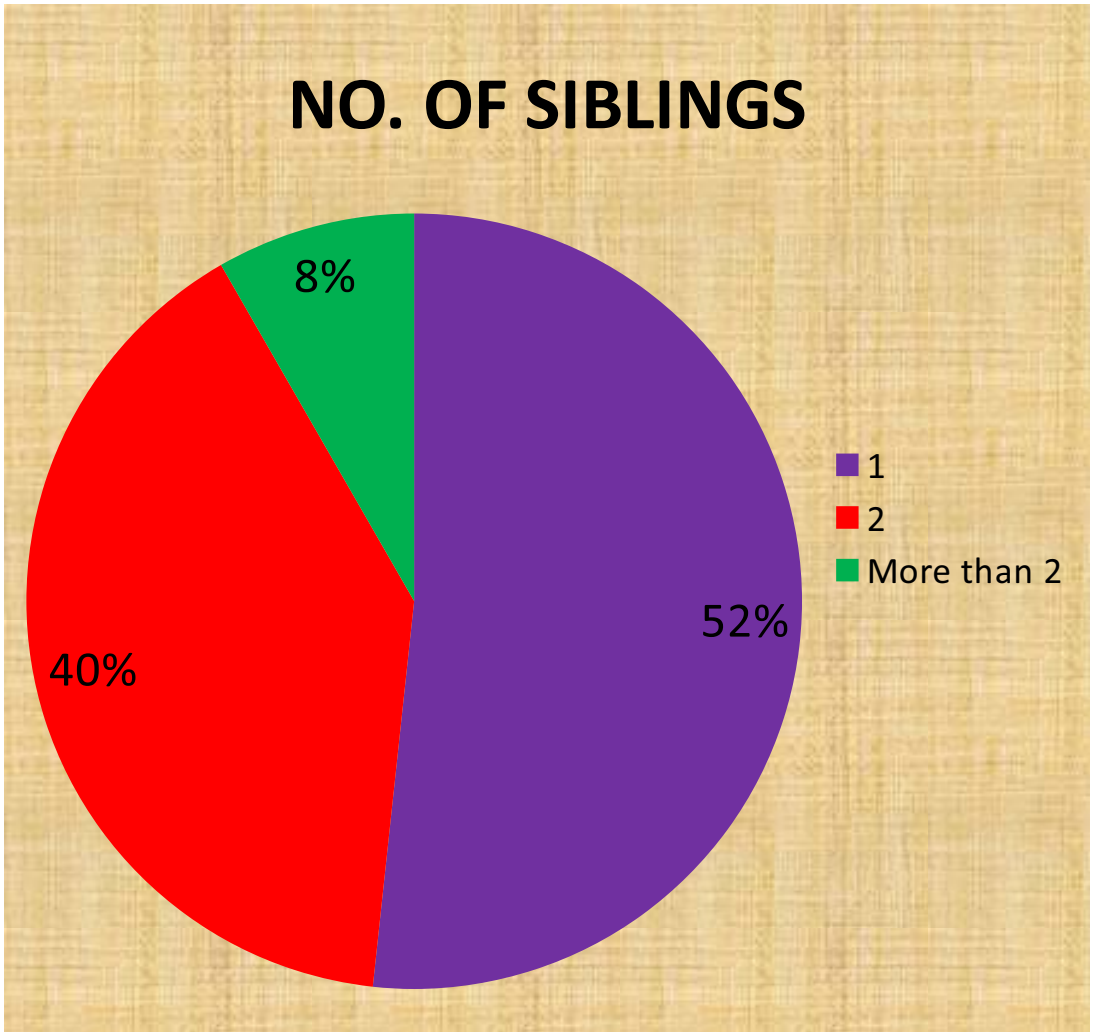


Figure: 5 frequency distribution and percentage on No. of Siblings among school children Aged between 5-10 years

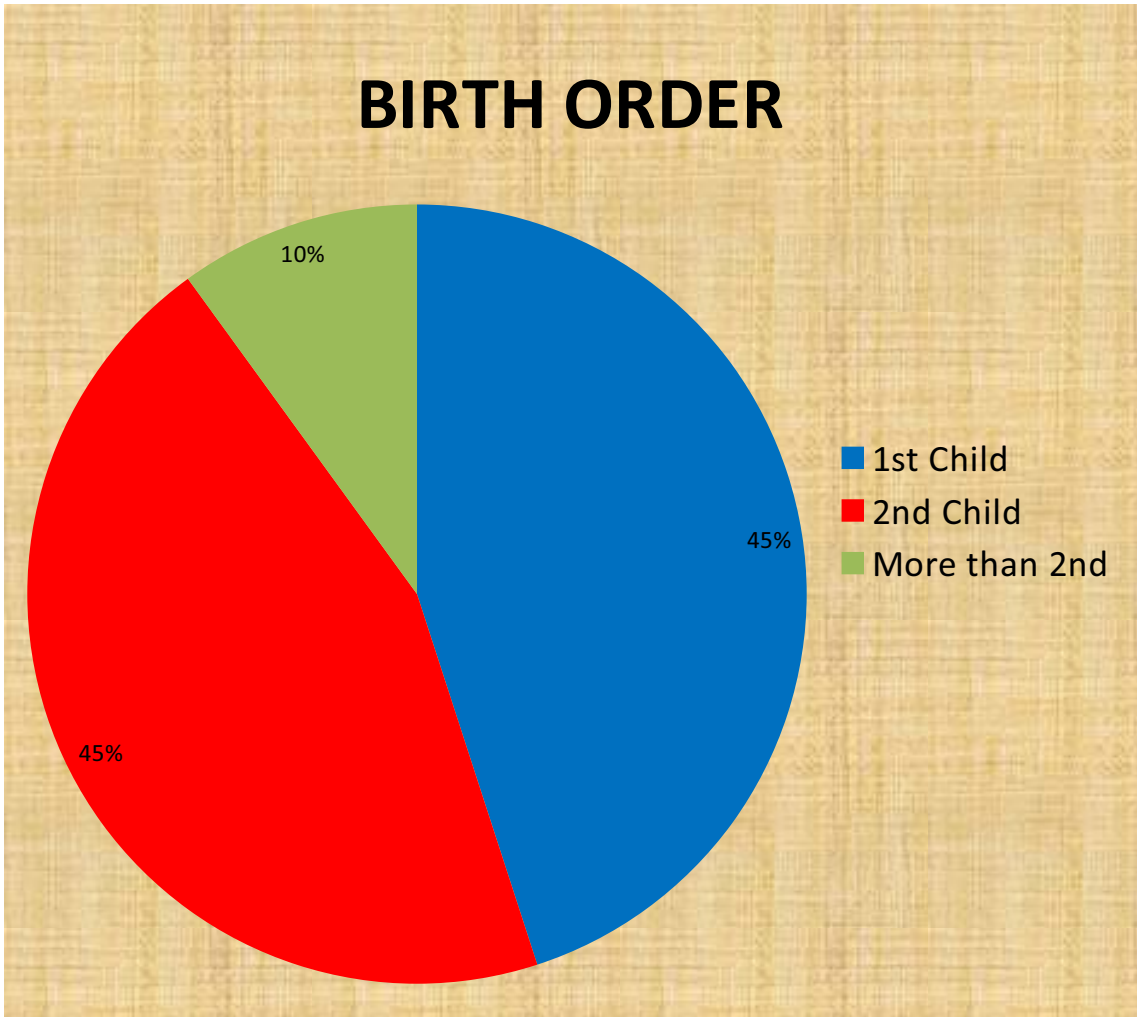


Figure: 6 Frequency distribution and percentage on birth order among boys and girls between the age of 5-10 years.

SECTION- II

FREQUENCY DISTRIBUTION AND PERCENTAGE ON BEHAVIOURAL DISORDERS AMONG BOYS AND GIRLS BETWEEN THE AGE OF 5-10 YEARS

NO=6O

S. N	VARIABLES	SEVERE		MODERATE		MILD		NONE	
		F	%	F	%	F	%	F	%
1	HABIT DISORDER	1	1.6%	23	36.5%	36	57.1 %	-	-
2	CONDUCT DISORDER	2	3.2%	19	30.2%	39	61.9%	-	-
3	EMOTIONAL DISORDER	1	1.6%	17	27%	42	66.7%	-	-

Table 2 shows that frequency distribution and percentage on level of behavioural disorders among boys and girls between the age of 5-10 yrs.

In Habit disorder, 1(1.6%) have severe problems, 23(36.5%) have moderate problems and 36(57.1%) have mild problems.

In Conduct disorder, 2(3.2 %) have severe problems, and 19(30.2%) have moderate problems and 39(61.9%) have mild problems.

In Emotional disorder, 1(1.6%) have severe problems, 17(27%) have moderate problems, 42(66.7%) have mild problems.

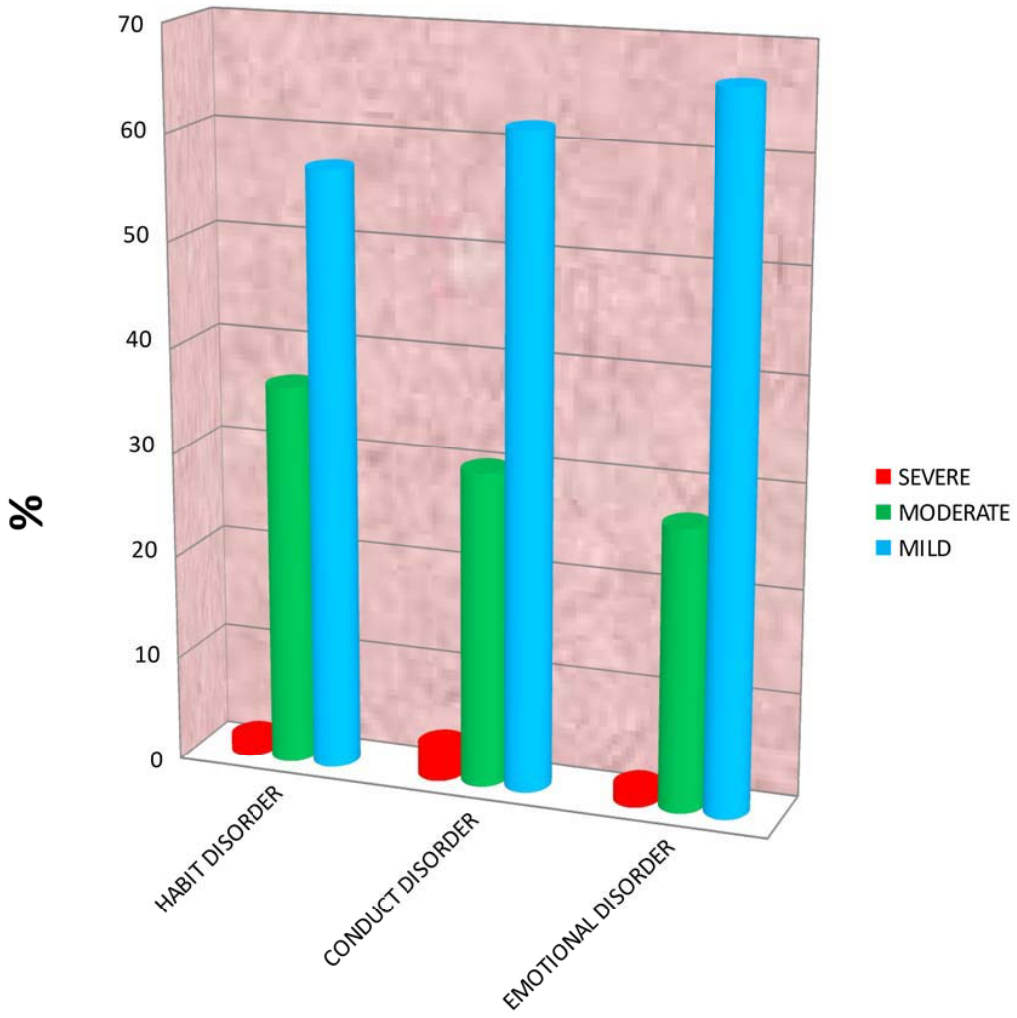


Table 2 shows that frequency distribution and percentage on level of behavioural disorders among boys and girls between the age of 5-10 years.

SECTION-III

ASSOCIATION BETWEEN AGE AND LEVEL OF BEHAVIOURAL DISORDERS

NO=60

Dimensions	Age (in years)	Calculated Chi Square value	df	'P' value	S/NS
HABIT DISORDER	< 7 yrs	2.216	2	5.99	NS
	7-10yrs				
CONDUCT DISORDER	< 7 yrs	0.476	2	5.99	NS
	7-10yrs				
EMOTINAL DISORDER	< 7 yrs	1.426	2	5.99	NS
	7-10yrs				

Table 3: shows that association between age and level of behavioural disorders

Regarding Habit disorder, the Chi-Square value was 2.216. The table value was 5.99 and is greater than Chi-Square Value. There is no association between age and habit disorder.

Regarding Conduct disorder, the Chi-Square value was 0.476. The table value was 5.99 and it is greater than Chi-Square Value. There is no association between age and conduct disorder.

Regarding Emotional disorder, the Chi-Square value was 1.426. The table value was 5.99 and it is greater than Chi-Square Value. There is no association between age and emotional disorder.

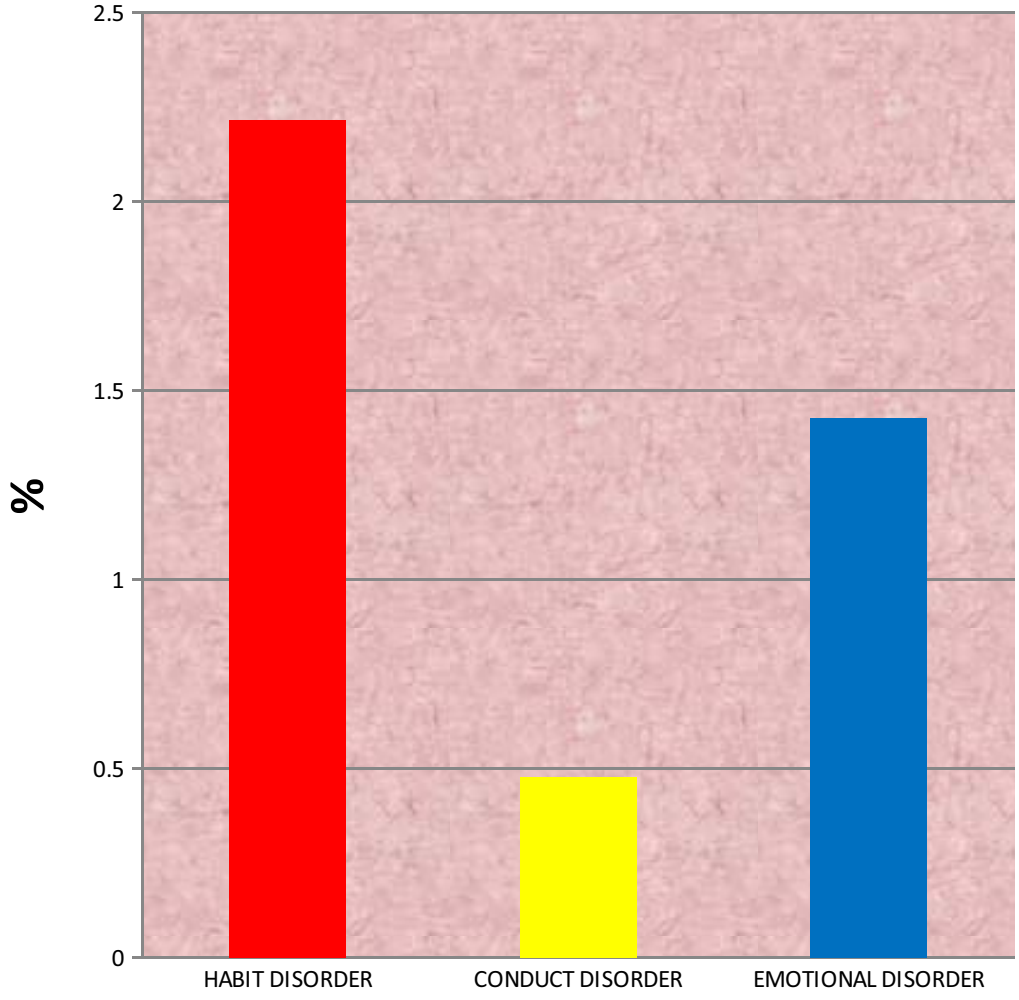


Table 3: shows that association between age and level of behavioural disorders

SECTION IV

ASSOCIATION BETWEEN GENDER AND LEVEL OF BEHAVIOUR DISORDER

NO=60

Dimensions	Gender	Calculated Chi Square value	Df	'P' value	S/NS
HABIT DISOREDER	Male	1.349	2	5.99	NS
	Female				
CONDUCT DISORDER	Male	8.622	2	5.99	S
	Female				
EMOTIONAL DISORDER	Male	0.859	2	5.99	NS
	Female				

Table 4: shows that association between gender and level of behavioural disorders.

Regarding Habit disorder, the Chi-Square value was 1.349. The table value was 5.99 and it is greater than Chi-Square Value. There is no association between gender and habit disorder.

Regarding Conduct disorder the Chi-Square value was 8.622. The table value was5.99 and it is lesser than Chi-Square Value. There is association between gender and conduct disorder.

Regarding Emotional disorder the Chi-Square value was 0.859. The table value was 5.99 and it is greater than Chi-Square Value. There is no association between gender and emotional disorder.

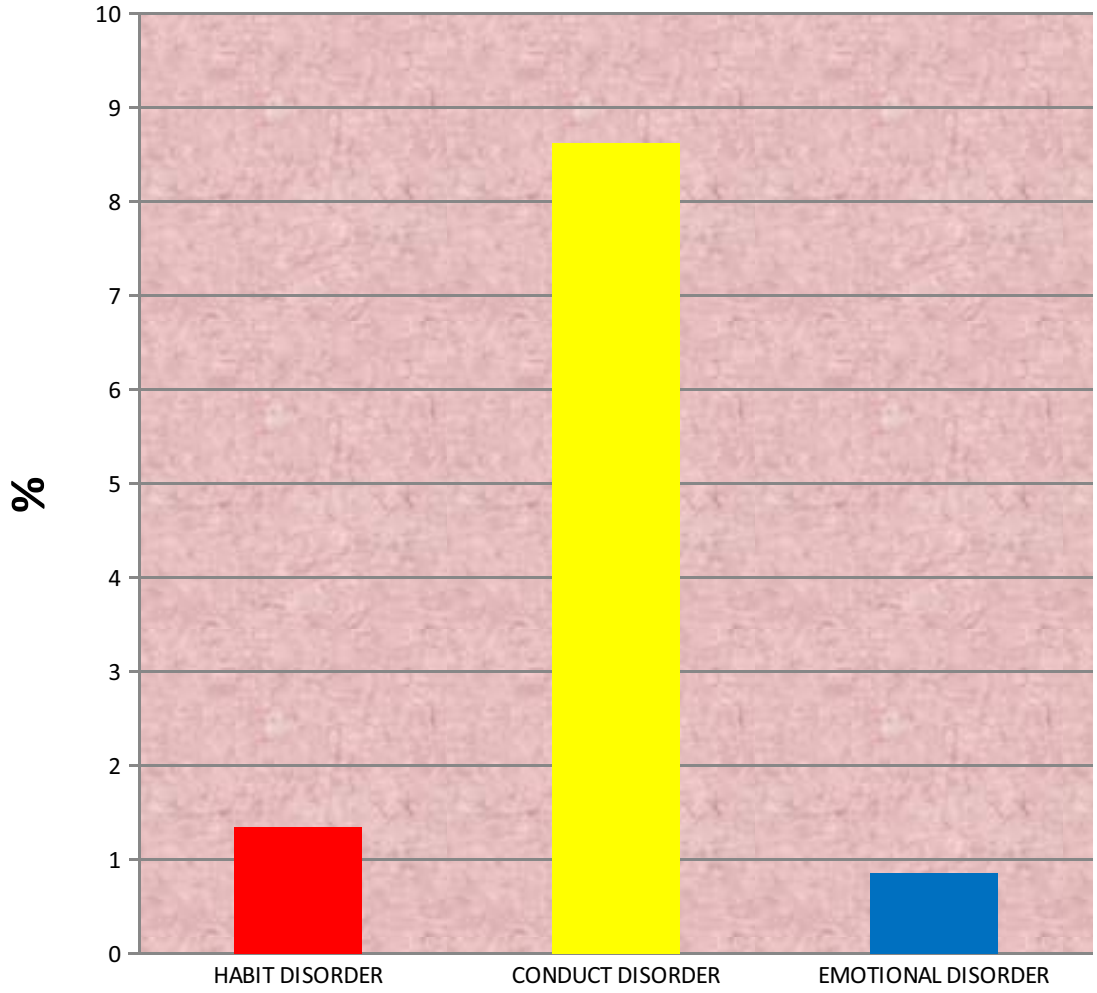


Table 4: shows that association between gender and level of behavioural disorders

SECTION V

ASSOCIATION BETWEEN OCCUPATION AND LEVEL OF BEHAVIOUR DISORDER

NO=60

Dimensions	Parents occupation	Calculated Chi Square value	Df	'P' value	S/NS
HABIT DISORDER	Government employees	11.771	4	9.49	S
	Self Employed				
	Private Employees				
CONDUCT DISORDER	Government employees	4.472	4	9.49	NS
	Self Employed				
	Private Employees				
EMOTIONAL DISORDER	Government employees	10.121	4	9.49	S
	Self Employed				
	Private Employees				

Table 5: shows that association between parents occupation and level of behavioural disorders

Regarding Habit disorder, the Chi-Square value was 11.771. The table value was 9.49 and it is lesser than Chi-Square Value. There is association between parents occupation and habit disorder.

Regarding Conduct disorder the Chi-Square value was 4.472. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between parents occupation and Conduct disorder.

Regarding Emotional disorder, the Chi-Square value was 10.121. The table value was 9.49 and it is lesser than Chi-Square Value. There is association between parents occupation and emotional disorder.

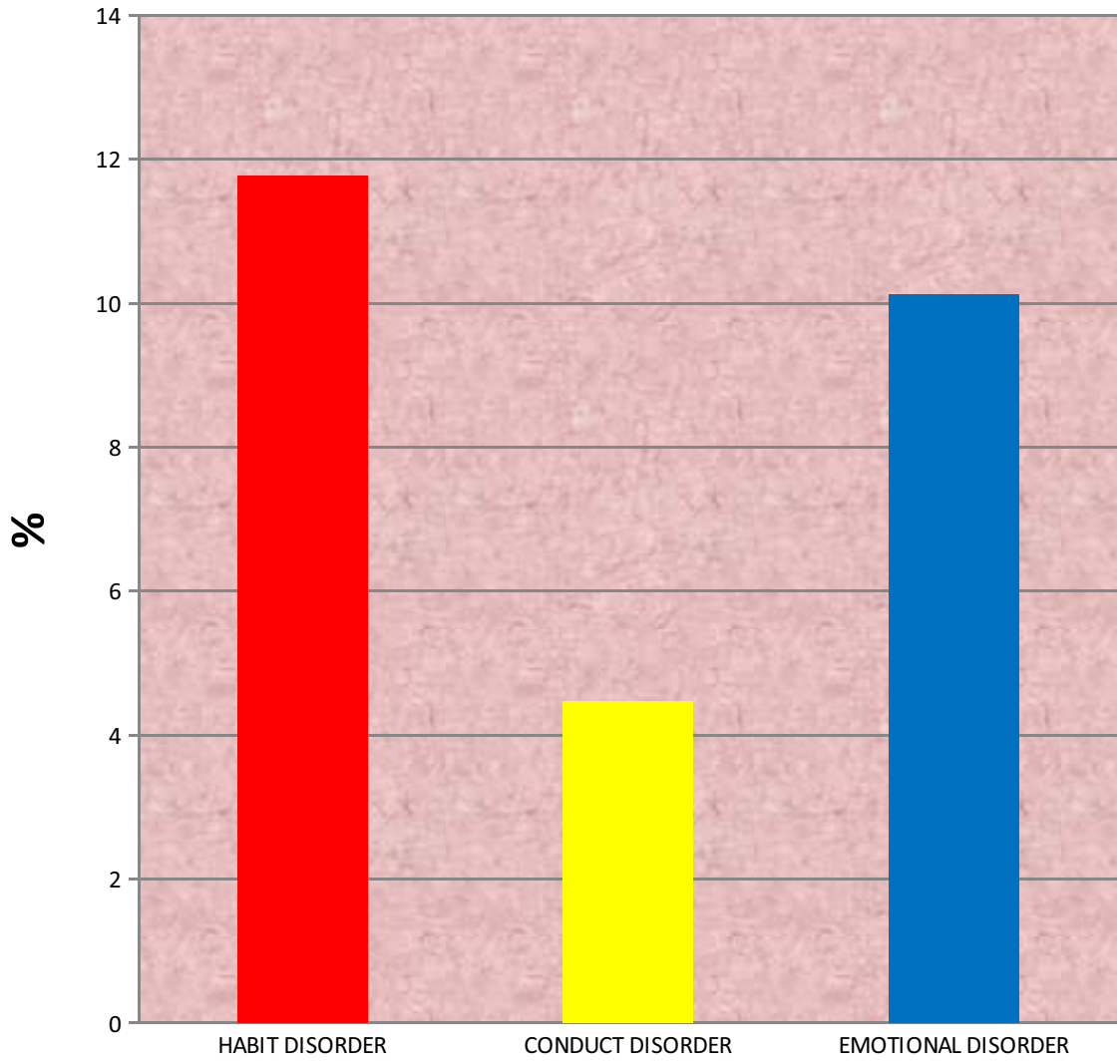


Table 5: shows that association between occupation and level of behavioural disorders.

SECTION- VI

ASSOCIATION BETWEEN MONTHLY INCOME AND LEVEL OF BEHAVIOUR DISORDER

N=60

Dimensions	Monthly income of parents	Calculated Chi Square value	Df	'P' value	S/NS
HABIT DISORDER	Rs<5000/month Rs5000-10,000/month RsAbove 10,000/month	3.224	4	9.49	NS
CONDUCT DISORDER	Rs<5000/month Rs5000-10,000/month RsAbove 10,000/month	2.968	4	9.49	NS
EMOTIONAL DISORDER	Rs<5000/month RsRs5000-10,000/month RsAbove 10,000/month	1.534	4	9.49	NS

Table 6: shows that association between monthly income and level of behavioural disorders.

Regarding Habit disorder, the Chi-Square value was 3.224. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between monthly income and habit disorder.

Regarding Conduct disorder, the Chi-Square value was 2.968. The table value was9.49 and it is greater than Chi-Square Value. There is no association between monthly income and conduct disorder.

Regarding Emotional disorder, the Chi-Square value was 1.534. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between monthly income and emotional disorder.

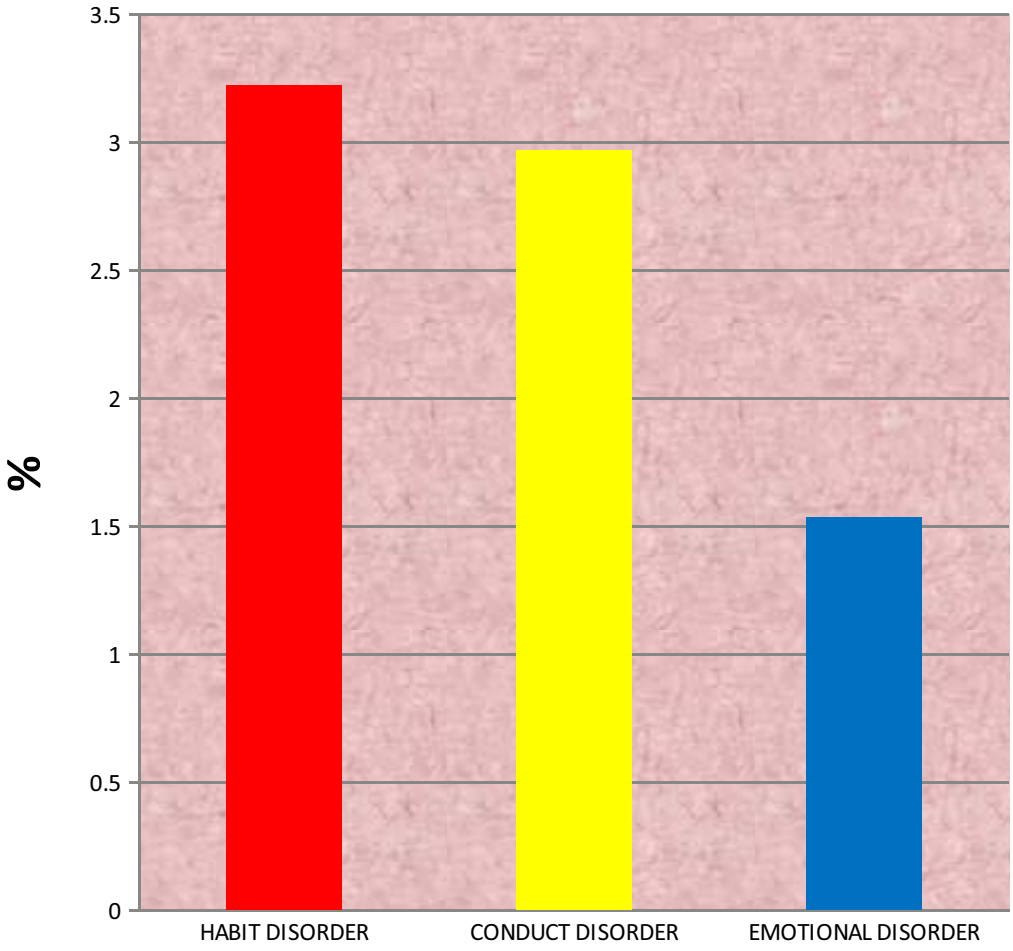


Table 6: shows that association between monthly income and level of behavioural disorders.

SECTION- VII

ASSOCIATION BETWEEN No. OF SIBLINGS AND LEVEL OF

BEHAVIOUR DISORDER

NO=60

Dimensions	NO. OF SIBILINGS	Calculated Chi Square value	Df	'P' value	S/NS
HABIT DISORDER	One	5.512	4	9.49	NS
	Two				
	More than two				
CONDUCT DISORDER	One	3.602	4	9.49	NS
	Two				
	More than two				
EMOTIONAL DISORDER	One	3.478	4	9.49	NS
	Two				
	More than two				

Table 7: shows that association between No. of siblings and level of behavioural disorders.

Regarding Habit disorder, the Chi-Square value was 5.512. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between No. of siblings and habit disorder.

Regarding Conduct disorder, the Chi-Square value was 3.602. The table value was9.49 and it is greater than Chi-Square Value. There is no association between No. of siblings and conduct disorder.

Regarding Emotional disorder, the Chi-Square value was 3.478. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between No. of siblings and emotional disorder.

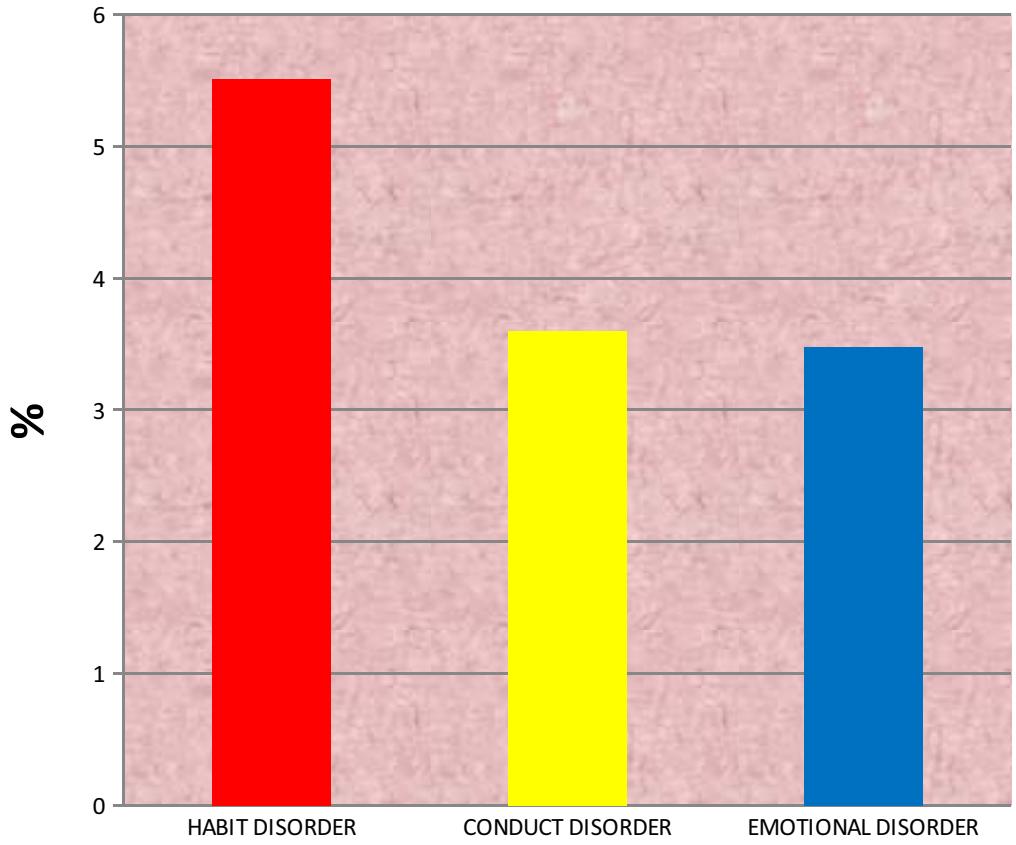


Table 7: shows that association between No. of siblings and level of behavioural disorders.

SECTION- VIII

ASSOCIATION BETWEEN BIRTH ORDER AND LEVEL OF

BEHAVIOUR DISORDER

NO=60

Dimensions	Birth Order	Calculate Chi Square value	Df	'P' value	S/NS
HABIT DISORDER	1st child	4.081	4	9.49	NS
	2ndchild				
	3rdchild				
CONDUCT DISORDER	1st child	2.405	4	9.49	NS
	2ndchild				
	3rdchild				
EMOTIONAL DISORDER	1st child	1.738	4	9.49	NS
	2ndchild				
	3rdchild				

Table 8: shows that association between birth order and level of behavioural disorders.

Regarding Habit disorder, the Chi-Square value was 4.081. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between birth order and habit disorder.

Regarding Conduct disorder, the Chi-Square value was 2.405. The table value was9.49 and it is greater than Chi-Square Value. There is no association between birth order and conduct disorder.

Regarding Emotional disorder, the Chi-Square value was 1.738. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between birth order and emotional disorder.

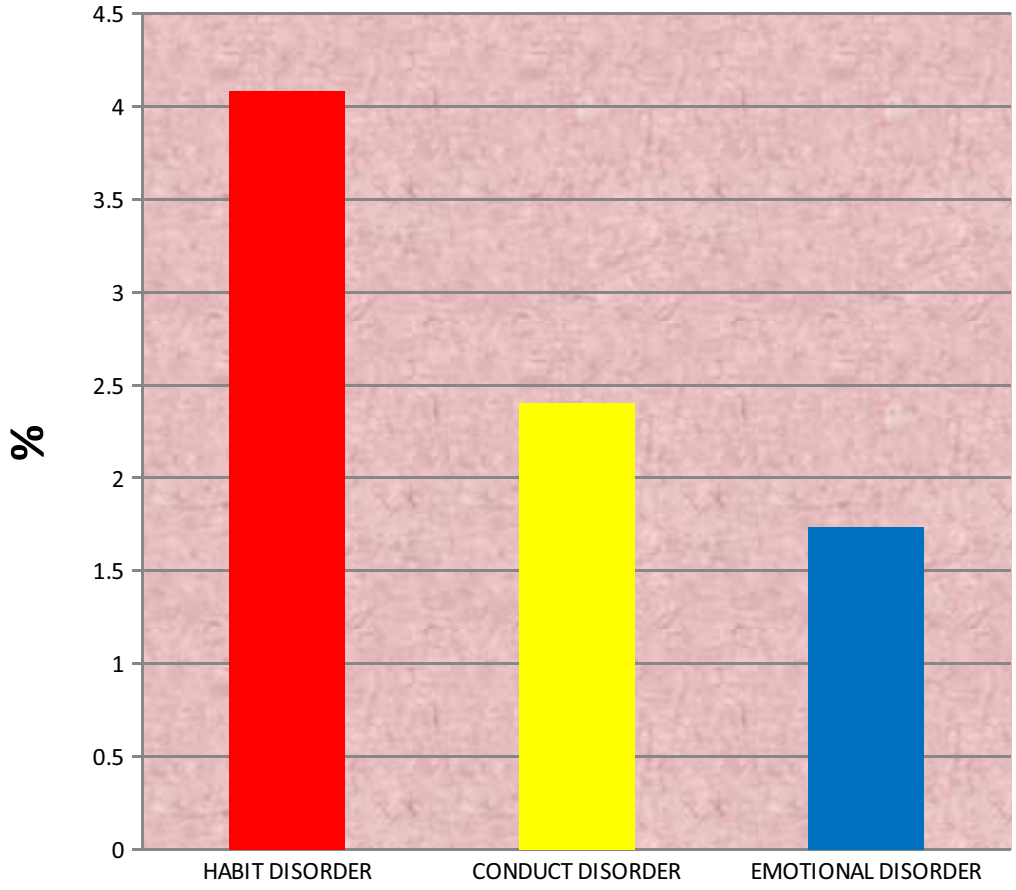


Table 8: shows that association between birth order and level of behavioural disorders.

SECTION: IX

LINEAR REGRESSION ON HABIT DISORDER AMONG

DEMOGRAPHIC VARIABLES

NO=60

DEMOGRAPHIC VARIABLES	UNSTANDARDIZED COEFFICIENTS		STANDARDIZED COEFFICIENTS	T	Sign
	B	STANDARD ERROR			
AGE	.190	.136	.178	1.395	.169
GENDER	.028	.135	.026	.208	.836
OCCUPATION	.248	.102	.309	2.424	.019
MONTHLY INCOME	.061	.131	.059	.465	.644
NO OF SIBILINGS	.195	.119	.238	1.630	.109
BIRTH ORDER	.173	.119	.215	1.456	.151

Table 9 shows that the standardized beta indicates that the relative contribution of all five dimensions of the independent variables in predicting habit disorder based on the percentage of prediction of Habit disorder-Age (17.8%), Gender (02.6%),Parents occupation (30.9%), Monthly income (05.9%) No. of siblings (23.8%) and Birth order (21.5%) Thus, these dimensions of readiness for the adoption of CEIT having influence on Habit disorder.

SECTION: X

LINEAR REGRESSION ON CONDUCT DISORDER

AMONG DEMOGRAPHIC VARIABLES

NO=60

DEMOGRAPHIC VARIABLES	UNSTANDARDIZED COEFFICIENTS		STANDARDIZED COEFFICIENTS	T	Sign
	B	STANDARD ERROR			
AGE	.146	.141	.130	1.031	.307
GENDER	.380	.140	.342	2.712	.009
OCCUPATION	.114	.106	.135	1.068	.290
MONTHLY INCOME	.212	.136	.195	1.556	.126
NO OF SIBILINGS	.075	.124	.087	.603	.549
BIRTH ORDER	.180	.123	.214	1.463	.149

Table 10. shows that the standardized beta indicates that the relative contribution of all five dimensions of the independent variables in predicting conduct disorder based on the percentage of prediction of Conduct disorder-Age (13.0%), Gender (34.2%),Parents occupation (13.5%), Monthly income (19.5%) No. of siblings (08.7%) and Birth order (21.4%) Thus, these dimensions of readiness for the adoption of CEIT having influence on Conduct disorder.

SECTION:XI

LINEAR REGRESSION ON EMOTIONAL DISORDER AMONG DEMOGRAPHIC VARIABLES

NO=60

DEMOGRAPHIC VARIABLES	UNSTANDARDIZED COEFFICIENTS		STANDARDIZED COEFFICIENTS	t	Sign
	B	STANDARD ERROR			
AGE	.074	.139	.073	.532	.597
GENDER	.100	.138	.099	.725	.472
OCCUPATION	.028	.104	.037	.268	.790
MONTHLY INCOME	.131	.134	.132	.974	.334
NO OF SIBILINGS	.122	.122	.157	1.003	.321
BIRTH ORDER	.083	.121	.109	.687	.495

Table 11. Shows that the standardized beta indicates that the relative contribution of all five dimensions of the independent variables in predicting emotional disorder based on the percentage of prediction of emotional disorder-Age(07.3%), Gender (09.9%), Parents occupation (03.7%),Monthly income(13.2%) No. of siblings (15.7%) and Birth order (10.9%) Thus, these dimensions of readiness for the adoption of CEIT having influence on Emotional disorder.

CHAPTER V

DISCUSSION

This chapter deals with the discussion of the study with appropriate literature, statistical analysis and the findings of the study based on the study objectives.

The aim of this study was to assess the behavioral disorders among boys and girls between the age of 5-10 years at Government Middle School, Sakkayanayakkanur, Dindigul.

The main study was conducted from sample numbering of 60 among boys and girls.

The behavioural disorder among boys and girls was assessed by questionnaire.

OBJECTIVES

1. To assess the level of behavioural disorders among boys and girls.

2. To find out the association between the behavioural disorders with demographic variables like age, gender, parent's occupation, monthly income, number of siblings, and birth order.

3. To find the linear regression an behavioural disorders among boys and girls with demographic variables like age, gender,parents occupation, no. of siblings, and birth order.

HYPOTHESIS

H_1: There will be a significant association between habit disorders with demographic variable like age, gender, occupation, monthly income, no. of siblings, birth order.

H_2: There will be a significant association between conduct disorders with demographic variable like age, gender, parents occupation, monthly income, no. of siblings, and birth order.

H_3: There will be a significant association between emotional disorder with demographic variable like age, gender, parents occupation, monthly income,no.of siblings, and birth order.

The first objective of the study is to assess the level of behavioural disorders among boys and girls between the age of 5-10 year at Government Middle School, Sakkayanayakkanur, Dindigul.

Table II Shows that frequency distribution and percentage on level of behavioural disorders among boys and girls between the age of 5-10 years.

In Habit disorder 1(1.6%) have severe problems, 23(36.5%) have moderate problems and 36 (57.1%) have mild problems. In Conduct disorder 2 (3.2. %) have severe problems, and 19 (30.2%) have moderate problems and 39 (61.9%) have mild problems. In Emotional 1(1.6%) have severe problems, 17(27%) have moderate problems, 42(66.7%) have mild problems.

The supportive study is **Salman Bandeali, Ahmed Jawad, AsmaAzmatullah, Medical Students, Aga Khan University, Karachi.2006.** A cross sectional study was conducted in three urban squatter settlements of Karachi from May to June 2006, targeting working children aged 5-16 years. Behavioural Problems of these children were estimated by using the self reported Urdu version of the Strengths and Difficulty Questionnaire. Out of a total of 225 respondents, 94.2% (n=212) males and 5.8% (n=13) females, the prevalence of Behavioural Problems among working children was found to be 9.8%. Peer problems were most prevalent (16.9%) seconded by Conduct problems (16.7%). Adverse family environment and work environment were closely associated with Behavioural Problems in these children followed by conduct problems (16.7%) and emotional problems (12.0%). The mean scores were 2.97,

2.55, and 3.35 respectively. Among the individual problems, emotional problems were most prevalent in children with a disturbed family environment (p=0.004). A high frequency (38.3%) of peer problems were found in those children who had been working for less than a year as compared to 14.9% who had work experience of more than five years (p=0.041).

The second objective of the study is to find out the association between the behaviourl disorders with demographic variables like age, gender, occupation, monthly Income, no. of siblings, and birth order.

TableIII: shows that association between age and level of behavioural disordesr. Regarding Habit disorder, the Chi-Square value was 2.216. The table value was 5.99 and it is greater than Ch- Square Value. There is no association between age and habit disorder. Regarding Conduct disorder, the Chi-Square value was 0.476. The table value was5.99 and it is greater than Chi-Square Value. There is no association between age and conduct disorder. Regarding Emotional disorder, the Chi-Square value was 1.426. The table value was 5.99 and it is greater than Chi-Square Value. There is no association between age and emotional disorder.

Table IV: shows that association between gender and level of behavioural disorders. Regarding Habit disorder, the Chi-Square value was 1.349. The table value was 5.99 and it is greater than Chi-Square Value. There is no association between gender and habit disorder. Regarding Conduct disorder, the Chi-Square value was 8.622. The table value was5.99 and it is lesser than Chi-Square Value. There is association between gender and conduct disorder. Regarding Emotional disorder ,the Chi-Square value was 0.859. The table value was 5.99 and it is greater than Chi-Square Value. There is no association between gender and emotional disorder.

Table V: shows that association between occupation and level of behaviourl disordesr. Regarding Habit disorder, the Chi-Square value was 11.771. The table value was 9.49 and it

is lesser than Chi Square Value. There is association between occupation and habit disorder. Regarding Conduct disorder ,the Chi-Square value was 4.472. The table value was9.49 and it is greater than Chi-Square Value. There is no association between occupation and conduct disorder. Regarding Emotional disorder, the Chi-Square value was 10.121. The table value was 9.49 and it is lesser than Chi-Square Value. There is association between occupation and emotional disorder

Table VI: shows that association between monthly income and level of behavioural disorders. Regarding Habit disorder, the Chi-Square value was 3.224. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between monthly income and habit disorder. Regarding Conduct disorder, the Chi-Square value was 2.968. The table value was9.49 and it is greater than Chi-Square Value. There is no association between monthly income and conduct disorder. Regarding Emotional disorder, the Chi- Square value was 1.534. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between monthly income and emotional disorder.

Table VII: shows that association between no. of siblings and level of behavioural disorders. Regarding Habit disorder, the Chi-Square value was 5.512. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between no. of siblings and habit disorder. Regarding Conduct disorder, the Chi-Square value was 3.602. The table value was9.49 and it is greater than Chi-Square Value. There is no association between no. of siblings and conduct disorder. Regarding Emotional disorder, the Chi-Square value was 3.478. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between no. of siblings and emotional disorder.

Table VIII: shows that association between birth order and level of behavioural disorders. Regarding Habit disorder, the Chi-Square value was 4.081. The table value was 9.49 and it is

greater than Chi-Square Value. There is no association between birth order and habit disorder. Regarding Conduct disorder, the Chi-Square value was 2.405. The table value was9.49 and it is greater than Chi-Square Value. There is no association between birth order and conduct disorder. Regarding Emotional disorder, the Chi- Square value was 1.738. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between birth order and emotional disorder.

Portive studies are, Gupta, Indira, et al. (2001). Prevalence of behavioural problems in school going children , Indian Journal of Pediatrics. A large number of children suffer from behavioural problems at one time or the other during their growing up years. The present study was conducted on 957 school children aged 5-11 years from an urban area of Ludhiana, India to assess the prevalence of behavioural problems. The study was conducted in two stages. In the first stage, a screening instrument Rutter B Scale was used to detect common emotional, conduct and behavioural problems in children. The responses were scored as 2, 1, and 0 respectively. 141 children scored more than 9 points and were included in the second phase of the study. Equal number of sex matched children scoring less than 9 points served as controls. Both the groups along with their parents were interviewed by a child psychiatrist. Only 117 and 124 children turned up and were included in the analysis. Based on the screening instrument results and parents' interviews, 45.6% of the children were estimated to have behavioural problems, of which 36.5% had significant problems. Conduct disorders (5.4%), Hyperkinetic syndrome (12.9%), scholastic under-achievement (17%), and enuresis (20.3%) were detected to be the main behaviour problems in children. Health education and counseling of parents especially fathers should be made available Close co-operation between school teachers, parents, and health care providers is suggested to ensure healthy development of children.

The Third objective of the study is to find out the regression of behavioural disorders among boys and girls between the age of 5-10 years at Government Middle School, Sakkayanayakkanu,Dindigul.

Table I X shows that the standardized beta indicates that the relative contribution of all five dimensions of the independent variables in predicting habit disorder based on the percentage of prediction of Habit disorder-Age (17.8%), Gender (02.6%), Occupation (30.9%), Monthly income (05.9%) No. of siblings (23.8%) and Birth order (21.5%) Thus, these dimensions of readiness for the adoption of CEIT having influence on Habit disorder.

Table X. Shows that the standardized beta indicates that the relative contribution of all five dimensions of the independent variables in predicting conduct disorder based on the percentage of prediction of Conduct disorder-Age (13.0%), Gender (34.2%), Occupation (13.5%), Monthly income (19.5%) No. of siblings (08.7%) and Birth order (21.4%) Thus, these dimensions of readiness for the adoption of CEIT having influence on Conduct disorder.

Table XI. Shows that the standardized beta indicates that the relative contribution of all five dimensions of the independent variables in predicting emotional disorder based on the percentage of prediction of Emotional disorder-Age (07.3%), Gender (09.9%), Occupation (03.7%), Monthly income(13.2%) No. of siblings (15.7%) and Birth order (10.9%) Thus, these dimensions of readiness for the adoption of CEIT having influence on Emotional disorder.

The supportive studies are , Behavioural problems are frequently associated with psychological problems hyperactivity, 2.3% of attention deficit hyperactivity disorder (ADHD), 3.6% of conduct disorder (CD) and another 3.0% for mixture of attention deficit hyperactivity and conduct disorder**(**M, Schmidt MH, Laucht M.2006**)** . Results of population based surveys suggest that about 40% of behavioural disorders children have behavioural and

emotional problems (Mc Gee etal, 1984). Psychopathology worsens with age in children with habit disorder (Rourke, 1988). Marked anxiety can appear when children with conduct disorder are confronted with reasonably simple arithmetic problems (Garnett &Fleischner, 1987). Ekblad (1990) found a positive correlation between psychological disturbance and poor school achievement among Chinese children. Shenoy&Kapur (1996) noted that 21 out of 88 children with behavioural disorder had a co-morbid psychological diagnosis. Kishore et al (2000) reported that 21 out of 56 children with specific developmental disorders of scholastic skills had a co-morbid psychological disorder.The NHIS assesses close to 50 000 families containing a total of approximately 10 000 youth (ages 4 to 17) each year. With the exception of pervasive developmental disorders, there has been considerable controversy about the validity of diagnosis of behavioural disorders in very young children (ages 2 to 5 years).

CHAPTER VI

CONCLUSION, IMPLICATIONS AND RECOMMENDATONS.

This chapter represents the summary, findings, conclusion, implications and recommendations which create a base for the future researcher for evidence based practice.

SUMMARY OF THE STUDY

A major topic for discussion today is the extent to which a behavioural disorder is a reality independent of social context versus a socially constructed phenomenon that depends, for its existence, on the demands, perception, values and judgments of persons in position of authority over students. One view is that students with behaviour disorders are different from most people in ways that are relatively constant across social contexts. This idea is associated with assumption that the primary causes of behavioral disorders are biological-that is neurological. Another perspective is that behavior disorder is mostly created by social demands and expectations; that is, behavior disorder is phenomena constructed by social contexts. Today people from nearly every walk of life recognize the term behavioural disorder, which is often used generically by the general public to indicate that someone's behaviour is highly unusual or inadequate for the circumstances.

STATEMENT OF THE PROBLEM

A descriptive study to assess the behavioral disorders among boys and girls between the age of 5-10 years at Government Middle School, Sakkayanayakkanur, Dindigul.

OBJECTIVES OF THE STUDY

1. To assess the level of behavioural disorders among boys and girls.

2. To find out the association between the behavioural disorders with demographic variables like age, gender, parent’s occupation, monthly income, no. of siblings, and birth order.
3. To find the linear regression an behavioural disorder among boys and girls with demographic variables like age, gender, occupation, no. of siblings, and birth order.

HYPOTHESIS

H1: There is association between habit disorder with occupation and no association between demographic variable like age, gender, parents monthly income, no. of siblings, birth order.

H_2: There is association between conduct disorder with gender and no association between demographic variable like age, parents occupation, monthly income, no.of siblings, birth order.

H_3: There is association between emotional disorder with occupation and no association between demographic variable like age, gender, monthly income, no.of siblings, birth order.

DATA COLLECTION PROCEDURE

Written permission was obtained from the Headmaster of Government Middle School, Sakkayanayakkanur, Dindigul. The students who fulfilled the inclusion criteria were selected by using Convenient sampling method. The researcher introduced herself to the students and developed good rapport with them for their co-operation. The researcher assured the participants for the confidentiality of their responses.

The purpose of this study was explained to every sample, so as to get their full co-operation. Adequate privacy was provided. Demographic data was collected through self report. After that assessing problems faced by students by using the questionnaire. Duration for collection of data is 30 minutes.

MAJOR FINDINGS:

In Habit disorder 1(1.6%) have severe problems, 23 (36.5%) have moderate problems and 36 (57.1%) have mild problems.

In Conduct disorder 2 (3.2 %) have severe problems, and 19 (30.2%) have moderate problems and 39 (61.9%) have mild problems.

In Emotional 1(1.6%) have severe problems, 17(27%) have moderate problems, 42 (66.7%) have mild problems.

Regarding Habit disorder, the Chi-Square value was 2.216. The table value was 5.99 and it is greater than Ch- Square Value. There is no association between age and habit disorder. Regarding Conduct disorder, the Chi-Square value was 0.476. The table value was5.99 and it is greater than Chi-Square Value. There is no association between age and conduct disorder. Regarding Emotional disorder, the Chi-Square value was 1.426. The table value was 5.99 and it is greater than Chi-Square Value. There is no association between age and emotional disorder.

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Regarding Habit disorder, the Chi-Square value was 5.512. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between no. of siblings and habit disorder. Regarding Conduct disorder, the Chi-Square value was 3.602. The table value was9.49 and it is greater than Chi-Square Value. There is no association between no. of siblings and conduct disorder. Regarding Emotional disorder, the Chi-Square value was 3.478. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between no. of siblings and emotional disorder.

Regarding Habit disorder, the Chi-Square value was 4.081. The table value was 9.49 and it is greater than Chi-Square Value. There is no association between birth order and habit disorder. Regarding Conduct disorder, the Chi-Square value was 2.405. The table value was9.49 and it is greater than Chi-Square Value. There is no association between birth order and conduct disorder. Regarding Emotional disorder, the Chi- Square value was 1.738. The

table value was 9.49 and it is greater than Chi-Square Value. There is no association between birth order and emotional disorder.

The standardized beta indicates that the relative contribution of all five dimensions of the independent variables in predicting habit disorder based on the percentage of prediction of Habit disorder-Age (17.8%), Gender (02.6%), Occupation (30.9%), Monthly income (05.9%) No. of siblings (23.8%) and Birth order (21.5%) Thus, these dimensions of readiness for the adoption of CEIT having influence on Habit disorder.

The standardized beta indicates that the relative contribution of all five dimensions of the independent variables in predicting conduct disorder based on the percentage of prediction of Conduct disorder-Age (13.0%), Gender (34.2%), Occupation (13.5%), Monthly income (19.5%) No. of siblings (08.7%) and Birth order (21.4%) Thus, these dimensions of readiness for the adoption of CEIT having influence on Conduct disorder.

The standardized beta indicates that the relative contribution of all five dimensions of the independent variables in predicting emotional disorder based on the percentage of prediction of Emotional disorder-Age (07.3%), Gender (09.9%), Occupation (03.7%), Monthly income(13.2%) No. of siblings (15.7%) and Birth order (10.9%) Thus, these dimensions of readiness for the adoption of CEIT having influence on Emotional disorder.

CONCLUSION

In this study for detecting children with Behavioural Disorders among boys and girls . The results of this study clearly indicate the relationship between psychological and neurological functions and behavioural disorder. Behavioural Disorders children are have some habit disorder, conduct disorder, emotional disorder. Behavioural Disorders children are overactive and more impulsive than normal children.

IMPLICATIONS

The data analysis results give rise to few suggestions to the nursing profession.

NURSING PRACTICE

- Awareness programme can be made as a routine in nursing services as an alternative therapy.

NURSING EDUCATION

- Awareness programme on prevention of behavioral disorders among children can be brought in detail in nursing curriculum from undergraduate level.

NURSING ADMINISTRATION

- In-service education can arranged to the staff nurses along with awareness Programme on prevention of behavioural disorder in both clinical and community setting.

NURSING RESEARH:

This research findings can be utilized for the development of research based protocols and polices in health care setting.

RECOMMENDATIONS:

- Same study can be conducted with large samples.
- Same study can be conducted among problems faced by children of behavioural disordesr.

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TITLE: A DESCRIPTIVE STUDY TO ASSESS BEHAVIOURAL DISORDER AMONG GIRLS AND BOYS BETWEEN THE OF 5-10 YEARS AT GOVERNMENT MIDDLE SCHOOL, SAKKAYANAYAKKANUR, DINDIGUL.

TOOLS:SECTION –A

DEMOGRAPHIC VARIABLES

1.How old you are?
- a. <7 years
- b. 7 to 10 years

2.What is your gender?
- a. Male
- b. Female

3.What is your father occupation?
- a. Government employee
- b. Private employee
- c. Self employee

4. What is your family income per month?
- a. Rs.<5000 / month
- b. Rs. 5000-10000/month
- c. Rs.>10000/month

5. How many siblings you have?
- a. One
- b.Two
- c.>Two

6.Order of brith
- a.1t Child
- b.2d Child
- 3.3d

SESSION B

HABIT DISORDER

1. Thumb sucking

a. Stressful situation

b.Hunger

c.Lack of attention from parents

d.Neglection

e.Emotional insecurity

f.Isolation

g.Lack of stimulation

h.Boredom feeling to the child

2. Pica

a.Geophagia

b.pagophagia

c.Hyalophagia

d.Trichophagia

e. Xylophagia

f.Urophagia

g.Coprophagi

h.Amylophagia

3. Nail Biting

a. Stressful situation

b.Neglection

c.anger

d.Nervous and anxiety

4. Temer Tantrums

a. Hunger

b.Lack of sleep

c.Over pampering

d.School aversion

5. Stuttering and Stammering

a. Speech

b.Reading

c.Nervous

d.Anger and tension

6. Teeth grinding

a. Sleeping time

b.Facial pain

c.Possible loss of teeth

d.Periodontal disease

7. Tic disorder

a. Psychogenic stress

b.Tension

c.Neurogenic

d.Physiology

8. Bed wetting due to

a. Stress

b.Anxiety

c.Sleep apnea

d.Night terrors

e.Very deep sleep

f.Poor day time toilet habit

9. Stranger Reaction

a.Very upset

b.Being silent

c.Worried facial expression

d.Fearful expression

CONDUCT DISORDER

10. A child with conduct disorder

a. Refusal to obey parents

b.Lack of empathy

c.Frequent lying

d.Suicidal tendencies

e.Aggressive to animals

f.Using weapons

EMOTIONAL DISORDER

11. A child with emotional disorder

a. Inappropriate action

b.Learning difficulties

c.Unhappiness

d.Depression

e.Feeling of fear

f.Anxiety about school matters

g.Hyperactivity

h.Agression

i.Self injurious behaviour

j.Withdrawal

k.Immaturity

HABIT DISORDER

S.NO	HABIT	OFTEN	OCCASIONALLY	NONE

1	Thumb sucking			
2	Pica			
3	Nail biting			
4	Teethgrinding			
5	Temper tantrums			
6	Bed wetting			
7	Tics			
8	Stranger reaction			
9	Stuttering / Stammering			

CONDUCT DISORDER

S.NO	CHARACTER	OFTEN	OCCASIONALLY	NONE
1	Refusal to obey parents			
2	Lack of empathy			
3	Frequent lying			
4	Suicidal tendencies			
5	Aggressive to animals			
6	Using weapons			

EMOTIONAL DISORDER

S.NO	CHARACTER	OFTEN	OCCASIONALLY	NONE
1	Inappropriate action			
2	Learning difficulties			
3	Unhappiness			
4	Depresstion			
5	Feeling of fear			
6	Anxiety about school matter			
7	Hyperactivity			
8	Aggression			
9	Self injurious behavior			
10	With drawal			
11	Immaturity			

CONTENT VALIDATION

The content validity was obtained from obtained from nursing experts. The suggestions given by 3 Medical experts and 2 Nursing Experts were incorporated and the Tool was finalized.

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   Bishop's College of Nursing,
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From

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II year M.Sc Nursing,
Mental health nursing,
Jainee College of Nursing,
Dindigul.

To

Assistant Elementary Educational Officer,

Assistant Elementary Educational Office,

Nilakottai.

Through the proper channel

The Principal,

Sir/Madam,

This is to bring to your kind information that, as part of syllabus requirement, I have to conduct a area project titled as "A descriptive study to assess behavioural disorders among boys and girls between the age of 5 to 10years".

I request you to allow me to do the data collection in your institution.Please do the needful.

Thank you

Yours truly

Date

Place (301332851)

From

Mrs.A.JohnJenippa,

II year M.Sc Nursing,
Psychiatric nursing,
Jainee College of Nursing,
Dindigul.

To

The Headmaster,

Panchayat Union Middle School,

Sakkayanayakkanur,

Dindigul.

Through the proper channel

The Principal,

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I request you to allow me to do the data collection in your institution. Please do the needful.

Thank you

Place

Yours truly

Date

(301332851)

PHOTO-1

RESEARCHER ASSESSING HABIT DISORDER

PHOTO-2

RESEARCHER ASSESSING CONDUCT DISORDER

PHOTO-3

RESEARCHER ASSESSING STUDENT BEHAVIOUR

PHOTO-4

RESEARCHER ASSESSING EMOTIONAL DISORDER